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CLINICAL LECTURES.

TYPHOID FEVER, DYSENTERY, ASTHMA.¹

BY ARTHUR V. MEIGS, M. D.,

VISITING PHYSICIAN TO THE PENNSYLVANIA
HOSPITAL.

Gentlemen: This patient, a young girl, 18 years of age, single, and a domestic, was admitted to the hospital on the twenty-eighth day of September. There is not much to be learned from her family history beyond the fact that her mother died of consumption. When a child she had scarlet fever, and three years ago she showed some disposition to sore throat. As you see, there is nothing very special in her past history. Her present illness began three weeks before her admission, which was one

week ago to-day. It came on with a chill, which was followed by a cough and expectoration, fever, headache, diarrhoea and stiffness of the legs. She had excessive sweating at night followed by weakness and cold sensations in the morning. Her nose had bled once or twice during this period.

On admission her temperature was $102\frac{1}{3}^{\circ}$, the next morning 103° , and that evening $103\frac{1}{3}^{\circ}$ —a temperature, rising, as you will notice, since admission. It then fell, and has since zigzagged between $99\frac{1}{2}^{\circ}$ and $101\frac{1}{2}^{\circ}$. This morning it is normal— $98\frac{3}{4}^{\circ}$. This does not mean, however, that the fever is broken; for it would then probably have fallen to a subnormal point. It will probably rise again to-night. Her tongue on admission was pale, flabby and tremulous; her circulation was poor, and her respiration jerky, with a slight expiring grunt. Her hands were also tremulous. She complained of pain in the lower part of her chest, especially on coughing. A physical examination, made a week ago,

¹ Delivered at the Pennsylvania Hospital.

gave the following results: Heart, negative, with the exception of a slight anemic murmur; lungs, anteriorly, filled with crackling râles, numerous and loud; posteriorly, some dulness at the right base; the spleen and liver dulness was marked by tympany; the belly was full and tympanitic and showed some rose-colored spots; the urine contained a trace of albumin.

To-day her expectoration is thick and ropy, but not at all greenish in hue, nor has it been nummular, as in phthisis. It is very viscid, so that when the cup is inverted it does not run out. Her tongue is slightly marked by the teeth, is tremulous, pale and moist, with a slight coating. It has not been dry at any time since her admission to the hospital. Her heart to-day reveals no departure from the normal condition, with the exception of a slight anemic softness in the first sound. Percussion resonance anteriorly is full and good, and equal on both sides. The respiratory murmur is good and clear. There is even good vesicular expansion, but there are some slight cooing râles on the left side, and none on the right. Posteriorly, at the apices, the percussion note seems good, and equal on the two sides. In the middle it is also fairly good and equal, but at the bases there is a difference. There is some impairment of resonance on the right side. On auscultation, the respiratory sounds are fairly good, with occasional faint cracklings here and there, which are decided at the right base. The abdomen is full, tympanitic on percussion, generally of a rather dusky hue, in fact she is slightly cyanotic, and there is a rose-colored spot here, which, however, is not typical. This, gentlemen, is the history and present condition of our patient.

Now our first duty is to make a diagnosis. We have here a woman whose previous history furnishes no special clue. She was a domestic in a boarding-house and worked until the day before her admission, when she was turned out-of-doors, and found her way here in the condition which I have described. On entering, she was placed upon five-grain doses of carbonate of ammonia every four hours, and eight grains of quinine a day, in two doses.

There are two methods by which we make a diagnosis: first, from observation of the clinical symptoms alone; and, second, by inference, excluding first one disease and then another until finally we fix upon one which seems to be that before us. In this case

there was much to be learned from observation. It was easy to observe that the patient had bronchitis, with slight acute catarrhal pneumonia—not acute croupous pneumonia, but one of those slow, creeping pneumonias where there is an exudation of cells rather than of fibrinous material. It would be easy, then, to say that this was an attack of broncho-pneumonia. But we go farther than this, and ask: Is there anything else? In my opinion, there is. The woman had, and has, typhoid fever, in addition to her lung trouble. I think she would by this time have been better, or worse, if she had her pneumonia alone. If you remember, she had some diarrhoea the day before admission, and has had some since. So, in addition to our actual observations about her lungs, we have this inference to aid us. It was difficult to decide at first, and it was only after two or three days that we arrived at the conclusion that this woman has typhoid fever.

There is usually more or less bronchitis in typhoid fever. From the nose-bleed, diarrhoea, and rose-colored spots, and from the condition of her tongue and the marked nervous symptoms she presented, we diagnosed typhoid fever. She has been stupid and dull and careless since admission. We do not find this condition in simple bronchitis, but it is peculiarly characteristic of typhoid fever.

In regard to prognosis, I need not say much, for she is improving considerably since her admission. If care is taken at the outset the patient has more chances for recovery. The principal thing that threatened this woman's life was the condition of her lungs, and this we treated at once with carbonate of ammonia and quinine. We do not give stimulants as much to-day as we used to do. If the patient holds her ground, we do not give any. This patient received stimulants only for twenty-four hours.

I now want to say a word or two upon the pathological lesions of typhoid fever. We are commonly taught that typhoid fever is a disease of the intestines, that the peculiar lesion is an ulceration of the ileum beginning at the cæcum and extending upwards indefinitely, involving few or many of the Peyer's patches. All this is very true; but if we stop here, it seems to me we have a very inadequate knowledge of the disease. We hear now of germs and of their influence in disease. We have been taught that these germs can be recognized by their ap-

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pearance—a fine microscopic lens being the only requisite. But now we are told that we must have pure cultures of them before we can recognize them. This seems to indicate a point of weakness somewhere in the ground assumed by bacteriologists. It is also said that there must be a soil fit for them to grow in: otherwise they will not produce their specific effect. All this, it seems to me, goes to prove that the influence of bacilli in disease is over-estimated, and that they are not of so much importance in the production of disease as is claimed for them. Now, if we accept the bacillus theory of typhoid fever, and look in the intestines for the bacilli, and treat the intestines alone, it seems to me we fail in our object; for, in my opinion, we must treat our patient with reference to the part most involved, which, in this case, is the lungs.

I have here notes from two autopsies made recently on patients who died here of typhoid fever. It is interesting to note the lesions found: The lungs showed unmistakably a considerable degree of catarrhal infiltration, and the whole lung seemed turned into pools of blood. I have no doubt that this was the condition in this woman. Then the kidneys were not structurally changed, but the cells were in a bad state, or, as Virchow calls them, in a state of "cloudy swelling." The mesenteric glands were all enlarged and almost in a state of suppuration. The spleen also was enlarged and in a state of cloudy swelling, as was also the liver. The heart showed a slight degree of endocarditis, and its muscular fibers were in a condition of brown atrophy: a granular condition with a destruction of the striæ. Now, considering all these points, would we not make a great mistake to treat these patients as if the disease was of the intestines alone? I believe that we would.

Dysentery.

This man, aged 24, was admitted on the sixteenth of September. He is a gardener. His mother died of heart disease. He uses tobacco and whiskey moderately. One month before admission he had a diarrhoea for four days. His present trouble began five days before entering the hospital, with diarrhoea attended with frequent evacuations, tenderness over the belly, free blood in the stools, and, on admission, retention of urine. His temperature was 101°, his pulse was 100.

The result of a physical examination was entirely negative. He had on his belly the "*taches bleuâtres*," large spots, blue in color, which do not disappear on pressure and are said to be characteristic of typhoid fever. Murchison says they are quite common. However, they had no bearing on his condition, as he had no typhoid fever. I do not think they have any diagnostic value, at least in this country.

The diagnosis here was plain enough. He had dysentery. He was placed upon the use of an ordinary diarrhoea mixture that we use here. Every two hours he took a pill containing opium powder, $\frac{1}{4}$ grain; capsicum, $\frac{1}{2}$ grain; tannic acid, 2 grains. After taking these for two days, he was no better. We therefore gave him a prescription which I consider very valuable. I do not know where it came from, but I believe it was used by an East Indian surgeon. The cardinal feature in treating this condition is opium, all other agents being but adjuvants to it. He was given ten drops of laudanum every two hours with ten drops of this mixture:

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This may be given often if required. Opium must be used in moderation, and the above dose is sufficient. It will not stupefy the patient. Larger doses do more harm than good. The patient is now almost recovered.

Asthma.

This man, 33 years old, was admitted on the 30th of September. He is a cigarmaker. His family history is negative. He does not use tobacco or whiskey. When seventeen he had an attack of rheumatic fever, and he had small-pox in 1870. He has been suffering from asthma, which formerly appeared each winter, but has troubled him more frequently of late. Last summer he had eight attacks. He has no cough between his attacks, but easily loses his breath. On admission his temperature was 97 $\frac{3}{4}$ °, his respiration was 30 per minute, his pulse only 62. There was no fever. His urine was normal. On auscultation to-day, his heart is normal. The percussion note on admission was hypo-resonant and his chest full of cooing and whistling asthmatic râles, with

prolonged expiration. To-day the resonance is rather high-pitched and short, and expiration is still markedly prolonged. There are signs that the asthma has produced some emphysema. Old asthmatics often present a marked degree of this condition.

His treatment has consisted in giving five grains of carbonate of ammonia every four hours, and ten drops of tincture of belladonna three times a day. At night $\frac{1}{2}$ grain of morphia and $\frac{1}{10}$ grain of sulphate of atropia was administered hypodermically. He has recovered from his present attack but we cannot guarantee him from future attacks.

MANAGEMENT OF HEMORRHAGE INCIDENT TO PLACENTA PRÆVIA.

BY HERMAN C. BLEYLE, M. D.,
OF NEWARK, N. J.

Gentlemen: The subject chosen for this paper, although a somewhat commonplace one, is, nevertheless, one familiarity with which is of the utmost practical importance.

I will therefore give a few experiences in the treatment of this most dangerous obstetrical contingency. At the outset of a discussion as to the proper procedure to which recourse should be had in cases of placenta prævia with antepartum hemorrhage, we are met with the fact that unanimity of practice among the recognized authorities is by no means the rule. In fact, the means advised range from the most risky and active procedures to the most veritable temporizing course—from venesection to transfusion. Nor are these differences of opinion confined entirely to treatment. It exists to the same degree in the explanation of the mechanism of the production of the hemorrhage, the physiological changes that are taking place in the lower segment of the uterus between the seventh and ninth months of pregnancy, and, in fact, in the very anatomy of the cervix itself. Out of the multiplicity of advice, discussion and argument, how shall we choose that proper course which each individual case of this dangerous condition demands? As a natural consequence, I have met this same uncertainty in the consulting room. There, as well as in the books, each practitioner

has his favorite mode of practice, and there, too, I have seen the patient gradually become almost exsanguine before the consultants could agree on a line of treatment for her relief. Often, in our experience, have we been summoned to a patient pregnant and near term, and on reaching the sick-room find her almost pulseless and exsanguinated, with blanched and anxious countenance, appealing to us for aid, not alone for herself, but for the unborn babe as well, and to halt at such a time between conflicting views as to treatment is to imagine condition of doubt in our profession which should not exist. For this reason it may, perhaps, not be unprofitable to us if I invite you to the bedside of a few patients, detailing the treatment employed, courting your most just criticism of the same, and soliciting your views based, as far as possible, on your own experiences as to its correctness. For convenience I will arrange the cases into two classes. 1st, those occurring before, and 2d, those occurring at labor; and, in order not to tax your patience unduly, will divest them as much as possible of all minutiae as to pulse, temperature, etc., giving only such salient points as will be necessary for the proper consideration of the case. They have been selected with the object of bringing up and inviting discussion on the following points: namely, the induction of premature labor, the proper use of the tampon, separation in whole or in part of the placenta, and rapid dilatation of the os manually or by means of instruments.

Case 1. Mrs. B., multipara, 28 years old; pregnant $7\frac{1}{2}$ months. This patient had progressed favorably during this pregnancy without the occurrence of anything of note until the night of Sept. 28, 1878, when a considerable hemorrhage took place during sleep. On vaginal examination, no dilatation of the os was discovered, and the patient declared she had suffered no labor-pain, and was at a loss for an explanation of the hemorrhage. Not being entirely certain at this time that the case was one of placenta prævia, nothing further than rest and opium were prescribed. There was no return of hemorrhage until Oct. 4, on which day, while in the performance of some household duty, she suffered quite a large loss of blood. On second examination, the finger pressed through the softened os could detect a soft, thick mass between it and the child's head. Feeling quite certain now that a placental presentation undoubtedly existed,

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the induction of premature labor was strongly advised. To this proceeding the relatives, however, objected, but deeming the patient's life would be greatly imperiled should any further hemorrhage take place, notwithstanding their objection I took the initiative step in inducing labor by using the tampon. The application of the tampon was followed during the night by labor-pains.

On Oct. 5, 9 A. M., the pains were quite regular. The tampon was partially forced from the vagina, and some flow had taken place during the night. The bladder was emptied by means of a catheter, and the remains of the tampon were removed. On removing a large clot of blood the os was found to be somewhat dilated, soft and dilatable. Fearing that a further and possibly a fatal hemorrhage might take place if the case was left to the natural powers, artificial dilatation by means of Barnes's dilators, and delivery by version were determined on. The dilators accomplished their purpose very effectually, and the hand was passed upward, separating the placenta on one side from its attachment, the membranes were ruptured high up, the feet seized and delivery rapidly accomplished. The after-birth was delivered shortly afterwards and no further hemorrhage took place. The child was still-born, but the mother made a good recovery.

In this case, it is just possible that this patient might have passed through her labor naturally and have made as good a recovery as if premature labor had not been induced by the tampon, and rapid delivery by the other means attempted; but how are we to feel assured on that point? By waiting until our patient is almost exsanguinated by repeated hemorrhages, before we resort to these means, when their employment is attended by an immensely increased risk? Clearly not. The view held by many, namely: when repeated hemorrhages have taken place and reasonable ground exists that placenta prævia exists, either the patient's life or her pregnancy must terminate—is a good one to accept and act on.

Now as to the best means to bring about this result. When it has been decided on to induce premature labor a good plan to follow is first to employ a large vaginal douche of warm water, introduce a sponge tent and then tampon the vagina effectually with either plain or borated cotton. If the os will admit of it, I sometimes insert a common rubber finger cot, distended with cotton, and dipped in some antiseptic solu-

tion, secured by a string to facilitate its removal and hold it in place by the tampon. I prefer the form of tampon commonly denominated "kite-tailed," using Sims' speculum to facilitate its introduction. This is left *in situ* if necessary for twenty-four hours. If not followed by pains it is then removed, the bladder emptied by the catheter, and a soft rubber catheter introduced into the cavity of the uterus and a second tampon applied. This generally accomplishes the purpose. Dr. Edward J. Ill, of this city, has devised an instrument, consisting of a soft rubber cone-shaped bag which, after introduction and distention by water, he claims answers an excellent purpose, not only as an oxytocic, but as a tampon as well. I can vouch for its utility in inducing pain, but, with all due respect for the Doctor's great medical ability, I am not enthusiastic in its efficiency as an hemostatic agent. The objection to its use is that it can only be employed after some dilatation has already taken place. The Doctor informs me he has used them in some cases with gratifying results, and after all, that is the end we are striving for. After the os is somewhat dilated, the Barnes dilators, in the main, answer excellently in completing this desired condition, and rendering the application of forceps possible, or version feasible.

In this case we also meet with a very common experience, namely, the opposition of the patient and her relations to the inauguration of—to them—so formidable a proceeding as the induction of premature labor. Nor does the opposition entirely rest with them. If your experience at all coincides with mine, you will find that the consultant physician occasionally will not accede to your views as to the necessity of the procedure, viewing it in the light of meddlesome midwifery.

Just here let me remark that, in my opinion, this term should be expunged from the text books on obstetrics. I think more lives have been sacrificed by its wrong interpretation than is generally acknowledged. I think its continued use in midwifery practice is only to furnish a screen behind which temporizing and inefficient practice seeks a refuge.

As a rule the relatives will not become convinced of the necessity of the induction of premature labor until the patient's life has become jeopardized by repeated hemorrhages. I hear some of you remark, that in such cases the physician would be justi-

fied in retiring from further professional connection when his patient will not accede to the carrying out of such procedures as the physician deems absolutely necessary for her safety. This is precisely the action I have taken in more than one of these cases. Other medical advice has assumed charge, the waiting policy carried out, and when the labor commenced and the real danger threatened, they were conveniently absent, and the responsibility that should have been assumed by them on account of the delay advised, was finally thrust on me, when nothing but vilification and damage to professional reputation was to be gained by this enforced attendance at the last juncture.

Case 2. Mrs. B., 25 years old, multipara; eighth month of pregnancy. When called to this patient I learned that she had suffered from number of hemorrhages, not alarming in quantity, excepting the one just preceding my visit. On examination, the finger could detect the placenta just inside the os. The latter was soft and dilatable. On auscultation no fetal heart could be heard. The patient felt assured that she had felt no life since the shock following the last hemorrhage. The examination had caused a still further hemorrhage, and an alarming syncope took place. On account of the suspected non-viability of the child, the extremely dangerous condition of the mother, and the lack of assistance to carry out any other procedure, separation of the placenta was decided on. The finger introduced through the os loosened as much of the placenta as was within reach. No more hemorrhage took place, and as soon as dilatation would allow, the forceps were applied and the child delivered as expeditiously as possible. The placenta followed shortly afterward. The child was stillborn, and all efforts attempted at bringing about resuscitation were unsuccessful. The mother made a good recovery.

The above case is one by no means infrequent in occurrence, in which we are called on to decide on the employment of a means which, while enhancing the safety of the mother, is very nearly certain to cause a destruction of all the chances the child has for further existence. The decision of this question, to my mind, is of such great moral responsibility, that if time would allow, I would not attempt its decision alone. The responsibility of human life is nowhere, in everyday medical practice, more

forcibly thrust on us than it is in just such cases as the one narrated. How shall we be governed in finally deciding this grave question? The existence of viability or non-viability of the child as demonstrated by auscultation must, in a large measure, guide us in its decision, as well as the dangerous condition of the mother which, while often not allowing of more formidable proceedings for her relief, must also have much weight in the choice of this means of her safety. If on auscultation no fetal heart can be heard no compunction should be felt in immediately separating the placenta. But what if the opposite is the case and the child is living? I hold that if the time will not allow of the employment of those means to dilate the os, and thus deliver by either forceps or version, and if the condition of the mother will not admit of further delay, then clearly we should not hesitate, repugnant as this procedure is to us, to immediately separate in whole or part the placenta from its attachment and give to the mother the greater chance of life to which she so justly is entitled.

The teaching of the Roman Catholic Church opposes any procedure which takes from the child any chance of existence, and this opposition is carried to the extent of forbidding the faithful to allow its employment, even at the sacrifice of the mother's life. But this circumstance should have no weight with us, even among the followers of this faith. Clearly the mother has the prior right of existence and such measures should always be employed having for their object the accomplishment of her safety, that of the child being of secondary consideration. If time will allow, I prefer the methods of rapid dilatation, because of the fact that the child's chances are not so seriously abridged. However I think my experience in the management of such cases teaches me to be satisfied when I am fortunate enough to have my efforts rewarded with the recovery of the mother only. Further, in my experience in the employment of separation of the placenta I have only seen two children born living. Dr. Jas. Y. Simpson gives a table of 141 cases in which this procedure was employed, attended with the birth of 33 living children—a result which I believe will not correspond with the general experience of most practitioners.

Case 3. Mrs. M., multipara, 35 years old; in the ninth month of pregnancy. Was called to this patient on June 3, 1874.

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at 10.30 P. M. The patient had had several hemorrhages, dating the first in the neighborhood of the seventh month. The losses of blood had not been large in quantity, but were of frequent occurrence. On this day, however, the hemorrhage was very profuse, and at my visit her condition was alarming. On examination it was learned that labor had commenced, the os was slightly dilated, and on searching the cavity the cause of the hemorrhages was explained by the fact that a lower lateral insertion of the placenta was presented. No pains of any account were present and absolute rest, and, internally, brandy, opium and ammonia, were prescribed. Externally, warmth was also employed. At this time it was learned from the patient that the membrane had ruptured. The administration of the stimulant was followed by some reaction, and I remained with the patient for $1\frac{1}{2}$ hours in order, should pains supervene, and hemorrhage recur, I would be ready to render such assistance as the case demanded. In the meantime I sent for additional assistance, but on account of the unseasonable hour and the distance of the residence (being on the outskirts of the city), I was unable to obtain it, so I was left to cope with the case alone. About 12 P. M., pains recommenced, as did also the flow, at first slight in quantity but after the fourth contraction she had a large hemorrhage and it became very apparent that temporizing was no longer to be entertained, the labor must be terminated, and that, too, as soon as possible. I immediately brought the patient to the edge of the bed, thinking that, on account of the softness of the os, rapid dilatation and delivery by version could be accomplished; judge of my astonishment, however, when, on introducing the finger, I discovered the os entirely dilated and the vertex presenting. As a forceps operation was entirely feasible that method of delivery was chosen. Careful traction was made and the head brought well down. Congratulating myself, that now no further hemorrhage would take place, on account of the direct pressure the child was exerting on the parts involved, I would allow her a short rest before completing delivery, but at the recurrence of the next pain a terrible gush of blood occurred and my patient sank lifeless on her pillow just as the child was born. The child was stillborn.

In this case the final and fatal loss of blood took place when the child was exert-

ing pressure to its fullest extent. Nor is this the only case in which this circumstance, namely, hemorrhage, when the child was very nearly delivered, has been noted. It is a question in my mind whether the teaching of the books is as correct on this point as has heretofore been received. The idea uppermost in our minds in the management of this variety of uterine hemorrhage, is to rely on the fact that the bleeding will finally be checked if we are only able to bring the child well down, and thus not only hasten delivery, but actually to utilize the child as a tampon. This reliance, in my experience, has received a rude shock on more than one occasion. Another case will be detailed in which the same loss of blood took place when the os was almost distended to its utmost limit by the body of the child. Now, as to the question of treatment employed in this case. You will remember this woman had suffered periodical losses of blood since the seventh month, and some hours preceding my visit had sustained a sudden large and dangerous loss, rendering her condition at the time of my visit one giving rise to great alarm. The os at that time was undilated, although dilatable. The membranes were ruptured and no flow was taking place. Should I have used the tampon? I am no believer in the employment of the tampon at, or near, term, after the membranes are ruptured and the waters evacuated, and for this reason: It is a well-known fact that damming up the mouth of the uterus by means of the tampon after the cavity has become emptied of its waters and hemorrhage is taking place, is simply to convert an open into a concealed hemorrhage. It is simply covering up the deadly process from our eyes. It is just as well known that the tampon being used, the cavity of the uterus, at term, can contain enough blood to terminate the life of the patient, and yet not one drop of blood show externally. But the advocates of the efficiency of the tampon claim that it has not only a restraining effect on the quantity of blood effused, but it has a hemostatic effect by its direct pressure exerted. In my case, could any tampon, however skillfully applied, have exerted any more direct pressure than did the child itself? Should I have immediately on my visit begun operations looking for an early emptying of the womb, or should I have done as I did, namely, as no hemorrhage was going on, wait for the recurrence of pains and hemorrhage before assuming

alone this great responsibility? I am fully satisfied that this particular case would have terminated the same, had I dilated and performed version, as it did, I leaving this natural process to go on to the extent of the few natural pains before interfering. The correct treatment this case should have received should have been instituted weeks before, namely, the induction of premature labor. It would have been much better to have terminated the pregnancy weeks before, than to have allowed it to proceed to that point when, alas, our efforts at ending the pregnancy only too often appear to terminate not only that condition, but the life of the patient as well.

Case 4. Mrs. M., 35 years old. Multipara. Ninth month of pregnancy.

This patient, like most of the others spoken of, had had periodical hemorrhages since the seventh month. As a necessary result she was reduced to a very dangerous condition of weakness.

I was called first during the night of Jan. 20, 1886, to render assistance to the midwife, to whose care it seems this patient had been entrusted since the seventh month. The patient had experienced a very large loss of blood, a short time prior to my connection with the case. On vaginal examination the os was found to be but slightly dilated, although some labor-pains had been experienced. The placenta could be distinguished, being implanted very near the internal os. The patient's condition would admit of no delay, so rapid dilatation of the os and rapid delivery were decided on. The patient was anesthetized and dilatation by Barnes' dilators was rapidly accomplished and version performed. The child was delivered living. During the process of delivery the mother suffered a large loss of blood, and immediately after the child's birth the pulse disappeared and to all appearance respiration also ceased. However, I directed the husband to assist me in raising her to an almost inverted position, and by our united efforts we held her suspended in that manner until we were rewarded by a return of respiratory effort. After a number of injections of brandy and digitalis reaction came on and she finally made a good recovery.

Case 5. Mrs. F., 39 years old. Multipara. Eight and one-half months pregnant.

This case was under the previous care of Dr. Rudolph Braun, of this city, who informed me that he was first called on April

22, 1888, on account of severe hemorrhage. He learned that she had suffered almost daily hemorrhages since April 16 preceding. On vaginal examination he found the os dilated to the size of a quarter dollar, and soft and dilatable, but no placenta could be distinguished. There were no pains. He advised rest and opium. On April 23, 9 A. M., the patient had a slight hemorrhage. No pains, and no change in the condition of the os. He visited the patient again in the evening on account of the profuse flow, which largely consisted of the waters, the membranes having ruptured. But still no pains were present and no further dilatation of os had taken place. On April 24, at 9 A. M., the patient again had a hemorrhage, alarming in quantity, and my assistance was requested in the case.

I found the patient almost bloodless and greatly shocked. Although in a condition plainly indicating the great hazard of the undertaking, I advised delivery by means of rapid dilatation of the os and version. After active stimulation she was anesthetized and the operation began.

The dilatation was easily and rapidly accomplished, and the hand, on being carried through the os, discovered what appeared to be a central implantation of the placenta. This was separated on the mother's right side sufficiently to allow the hand to pass. This action was followed by additional hemorrhage, to check which the whole placenta was detached and expelled into the vagina. The hand was carried rapidly upwards to the fundus, and owing to the evacuation of the waters on the proceeding, great difficulty was experienced in rupturing the membranes. They were, however, finally torn, and, in the hurried attempt at version, I committed the error of hooking an elbow under the impression it was the knee and an arm was brought down. It will be remembered that during all of this time the placenta was hanging loosely in the vagina, and consequently, without the shadow of doubt, no utero-placental circulation could have been taking place.

A second and more skilful attempt at version was then made, and the child was shortly afterward delivered, which, notwithstanding the above-mentioned conditions, immediately cried on being born, needing absolutely no efforts at resuscitation. I am positive that the placenta was entirely separated at least eight minutes before the child was born, and I will not even attempt to

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plain the fact that asphyxiation in no degree existed. The mother made a rapid and good recovery.

This last case is an example of one of the most common conditions under which I have been brought to face this most dangerous trouble.

The patient, having for days suffered successive losses of blood, is finally reduced to a condition of collapse. The os is undilated, no pains are present, and nature has as yet made no effort to empty the womb. To wait longer is only to add one more to the already large mortality list from this cause, and to interfere by efforts at terminating the pregnancy, is to assume the terrible responsibility of perhaps ending the patient's life during such attempts. Which course shall we pursue? For this is the case that admits of no indecision. To my mind there is but one course, and that is to terminate the pregnancy then and there. I believe—and this belief has been gained by hard bedside experience—that in the majority of cases of placenta prævia at term, or during labor, after large hemorrhages, and particularly in multiparæ, that the os very readily admits of dilatation, either manually or instrumentally. Of the two methods I prefer the hand. The Barnes dilators often accomplish the purpose and just as often they utterly fail. When distended sufficiently to exert a dilating effect they are apt to slip either inwards, into the uterine cavity, or outwards into the vagina. Again, they rupture very easily on account of the hyper distention to which they are generally subjected, both above and below the point of opposition to dilatation. For some years I have relied almost entirely on the hand in bringing about dilatation in just these cases. I have no doubt of the justifiability of manually dilating the os and forcibly terminating the pregnancy in this condition, on the grounds of, first, feasibility; second, comparative safety; third, its affording some chances to the child of further existence. I do not think that the first and last grounds need any defence at my hands; they are generally acknowledged and accepted as fact. On the question of the safety of this proceeding some difference of opinion may exist. Strictly, the operation is only safe comparatively speaking, and its performance is not to be viewed as devoid of danger. The chief danger to be apprehended lies in the infliction of the additional shock. As a rule, I think shock, more than further

hemorrhage, is to be feared in the operation. The employment of an anæsthetic aids materially in averting the shock. In a large number of these cases the os can be rapidly dilated manually with safety to mother, for the reasons that the placenta never is attached to any portion of the cervix proper, that the form called central implantation is rare, and the fact that in the great majority of cases the form called by some writers latero-cervical is more often met with. In these latter cases, after slight dilatation, we can partially separate the placenta from its attachment to that portion of the uterus which must be stretched during the passage of the child's head, and thus check hemorrhage. Again, after dilatation and during the performance of version, the hand and arm act as important hemostatics by their direct pressure on the torn utero-placental vessels. Other grounds might be adduced, but that would involve a discussion on the anatomy and physiology of the lower segment of the uterus and cervix, which is not exactly the object of this paper.

In my experience no great loss of blood, as a rule, is provoked by its performance, and I am satisfied that when not too long delayed it offers one of the best safeguards to the mother that is within our power to afford her. I would not hesitate to employ this means, under the proper conditions, knowing by experience of its safety, and knowing, just as well, the great responsibility its employment entails. Too often its ill success is due to the fact that many of these cases are allowed to reach that point when interference through any justifiable means only has the appearance of hastening an unfavorable termination. I believe these delays will always occur on account of one reason or another. Sometimes it will be the thought that if we do not attempt some hazardous proceeding the hemorrhage will not recur, no more shock will be inflicted, and may be our friend, good old mother Nature, will make all things right. Sometimes the delay will be caused by the fear that comes to all of us, that if we do not save both mother and child, or if we assume a responsibility that may sacrifice both, we will either suffer in reputation, or receive only vilification for our pains. But, gentlemen, ingratitude for ministrations at our hands or duties well performed is our common lot, and that fact should not deter us in just such cases as the one last cited from hopefully and fearlessly discharging a grave responsibility, re-

lying only on an approving conscience for that justification only too often withheld by those for whom responsibility is incurred.

COMMUNICATIONS.

PERITYPHLITIS.

BY JOSEPH H. HAYDON, M. D.,

NEWARK, N. J.

The term "typhlitis" signifies inflammation of the vascular mucous surface, or all the coats of the cæcum, and "perityphlitis" inflammation in the abundant connective tissue which attaches the cæcum to the psoas and iliac muscles; and, to quote Dr. James T. Whitaker in his article on this subject, in Pepper's System of Medicine, typhlitis is, strictly speaking, limited to affections of the cæcum and its appendix vermiformis, while perityphlitis is mostly due to an extension of the inflammation to the peritoneal envelope of these organs. Still these diseases are so closely related to each other that it is highly proper, in a paper of this character, to consider them both under the one head of Perityphlitis.

So, at the outset, you will understand that it is not my province to discuss this subject in any classical or ponderous manner, but only to describe two cases, and intersperse their histories with a few remarks upon the etiology, symptomatology, and treatment of the disease. I will here mention some of the causes of this disease. They are many and varied; for instance, severe colic, the lodgment of hardened fecal matter, stones of fruit, may, either of them, singly or together, by becoming impacted in the vermiform appendix or cæcum, give rise to dangerous inflammation ending in abscess. This subject, however, in all its details, is so familiar to you all, that I do not think it necessary to offer any further explanatory remarks upon it, but will proceed at once to relate some experiences of my own with this malady, hoping that they may be fairly interesting.

Case I. This patient came to my knowledge just after I had received my diploma, in March, 1872. The patient, a female, applied by messenger to the Clinical Department of the University of New York City and asked to have a physician sent to her immediately. Professor Aylett, a blind

Quiz Master in whose class I had been, asked me if I would like to go. I consented, and he and I went together. I told the symptoms of the case while he listened, and never a word else passed between us until when he had arrived at what seemed to him a satisfactory conclusion, and said, "Perityphlitis. I can't see to use the knife when the time comes and I am afraid to trust you." To say the least I was mortified, but said nothing, and the Professor, after deliberating for some minutes, advised me to appeal to some one else to aid me, which later on I did, but in the meantime, being somewhat chagrined by his want of confidence in my ability, I had determined upon my own course and with all possible expedition and care made notes of the features of the case, then went home and read up the subject from its incipency to its finish, which, together with opening the abdomen over the right iliac fossa down to the cæcum, on many cadavers, in the dissecting room of the college within the next few days, made me pretty well acquainted with what I might soon be called upon to attempt. My patient, a Mrs. Grier, who seemed to be a woman of fair constitution, but nervous temperament, was, on the morning of March 16, 1872, seized with sudden pain, without premonition, which was colicky in character, and located in the abdomen. Vomiting occurred every fifteen or twenty minutes. The abdomen was tensely swollen, and tender to the touch, especially so over the right iliac region. The woman had eaten heartily, or rather inordinately, of grapes, one or two days previously. The pain was paroxysmal in character, and very severe, and had not been relieved by all the domestic remedies which had been used through the night. I immediately gave her hypodermically, first fifteen, and in one hour after twenty minims of Magendie's solution of morphia; this had the desired effect, for soon after the second dose she was resting easily, and remained so for five or six hours, when the pain returned and morphine was again administered. The pulse was 120, the respiration 36, and the temperature 105°.

On March 17 I found that the patient had passed a restless night, suffering excruciating pain in the bowels except when partially under the influence of morphine. At this time the tenderness over the abdomen was so great that hardly any examination of the bowels, however gentle, could be borne; a prominent fulness over the right side,

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especially noticeable in the ileocæcal region, was now well marked; I ordered ten or twelve leeches to be placed over this side and administered half a grain of morphia hypodermically, and left the case until evening, when I found that the leeches had done their work as far as drawing the blood was concerned, but the patient's general condition was about the same as it had been at the morning visit, so I advised continuance of morphia, in half-grain doses every two or three hours, until perfect rest ensued; and the whole abdomen to be covered with hot poultices. The pulse was still 120, the respiration 36, and the temperature 105°.

For the next two days there was no apparent change in the patient's condition. I then called Dr. Early, a friend of mine, to see the case with me; after examination of the patient, he confirmed my, or rather my blind preceptor's, diagnosis of ileocæcal abscess, but advised delay in operative interference and suggested the application of tincture iodine over the seat of the abscess and the continuation of the hot poultices over the whole abdomen. This line of treatment followed for three days longer, the patient's general condition apparently becoming much improved; she partaking of considerable nourishment, without any tendency to nausea, and having only very slight pain at any time. This condition of affairs continued uninterruptedly for about three days more, the patient refusing to permit any kind of an operation, even of an explorative character, when, all at once, I was summoned to find a return of all the unpleasant symptoms; increase of pain over tumor, the deeper outlines of which could now be more distinctly defined. The skin was natural in color and pliable, no fluctuation present, and no rigor. The point of greatest tenderness was about an inch inside of the anterior superior spinous process. The pulse was 124, and the temperature 104½°. The indication for operative interference being apparent, I explained to her the danger she was in and gained her reluctant consent. I at once summoned Dr. Early to assist me, and, the patient having been fully etherized, an aspirator needle was introduced into the tumor at the point of greatest tenderness and dulness, the only result of this procedure, after penetrating about two inches, was in obtaining probably a drachm of sanguineous pus, strongly fecal in its odor. Satisfied now of the correctness of our opinions, I next made an incision

three inches in length over the seat of puncture of the aspirator needle, and cut down through the integument, and tendinous and muscular structures to the transverse fascia. Here in bold relief was an apparently hard, unyielding tumor, without the least semblance of fluctuation, but of a somewhat doughy consistency; it was the work of only a few seconds more until, cutting the transversalis fascia and enlarging somewhat the first opening made, reward came immediately in a free discharge of pus, mixed with a large quantity of grape seeds. Before dressing the wound an exploration was made of the abscess cavity by introducing a finger, by which method I removed a mass of agglutinated grape seeds, probably as large as a small-sized hickory nut. The wound was now packed with pledgets of carbolyzed lint, over which was placed a poultice. The next morning the cavity of the abscess was thoroughly washed out with a carbolic acid solution (one fluid drachm of the acid to a pint of water) and more grape seeds were brought away. A rubber drainage-tube was then inserted in the wound and the application of warm poultices continued; morphia, in doses of a quarter to a half a grain, was also given two or three times a day. From this time on the patient made a good recovery, sleeping well, and taking liquid nourishment with a relish. The swelling and tenderness of bowels disappeared entirely, and the bowels acted naturally and regularly once a day. The wound healed by granulation, but without much discharge.

A point of interest in this case is the almost positive certainty that the immediate cause of the trouble was the accumulation of the great quantity of grape seeds in the cæcum. Some writers on this subject doubt that the lodgment of foreign bodies cause such a condition.¹

It may be in place to say a few words in reference to the many diseases with which typhlitis and perityphlitis may be confounded. Among these are acute peritonitis of idiopathic origin which, from its suddenness and severity, may be thought to have its origin in perforation of the appendix; also the peritonitis caused by the perforation of the bowel in enteric fever. The same may also be said of all those cases in which peritonitis arises from the perforation of a

¹ See Dr. Ryerson's article in the Transactions of the Medical Society of New Jersey, page 100.

hollow viscus or of an hydatid or other abscess, or from the extension of inflammation from various pelvic organs, especially those of the female. Again, the local supuration which attends many cases of perityphlitis or typhlitis may, in some of its stages, be confounded with abscesses of other kinds. Among these may be enumerated, psoas abscesses and abscesses extending from the kidney, the spinal canal and the pleura. The disease may similarly be mistaken for ovarian tumors of inflammation, or for cancerous tumors of the venterilli or glands in the vicinity of the cæcum, and, even under some circumstances, for aneurismal tumors.

Case II. Female; seven years old. The attending physician's diagnosis was acute peritonitis, with intestinal obstruction at the ileocæcal junction; and he, Dr. Swan, gave the following history of the case: For the two weeks previously the patient had complained of lancinating pain over the abdomen, which was especially acute in the right iliac fossa. The child attributed her trouble to the bruising her right side by falling over a pile of wood one evening, as at that time she had experienced considerable pain all over that part of her body, from the inguinal region up to above the point of the hip bone; this pain, however, passed off in a few hours, but afterwards returned with renewed intensity and severity, and had remained severe up to the time of my visit, notwithstanding Dr. Swan had administered opium and morphine in what he deemed sufficient quantities, and had also applied warm poultices continually.

On examination the abdomen was found to be greatly swollen and tympanitic, with marked tenderness over its entire surface, but particularly so over the right iliac region, rendering a thorough examination almost impossible; but sharp inspection seemed to reveal a slight elevation in the abdominal wall, at point of the greatest tenderness, so suspecting the formation of a perityphlitic abscess, the employment of six or eight leeches, and a continuation of the warm poultices was advised. This course had the effect of relieving the symptoms of general peritonitis and locating the trouble in the right iliac region, thereby confirming the suspicion that this was the locality principally involved. The pulse fell from 120 to 100 and the temperature from 103° to 100°, and for the next five or six days, during which time I did not see the case, the patient re-

mained quite comfortable, and the general indications pointed to an entire subsidence of all heretofore unpleasant symptoms. The seventh day after my first visit, and the twenty-first from the commencement of the trouble, I was again summoned to the case. On examination I found over the outer half of Poupart's ligament and very close to it, a circumscribed, deep-seated tumor, extremely tender to the touch, dull on percussion, but not fluctuating. The patient was suffering great pain. Her pulse was 136 and rather feeble. The temperature 105°, and the patient's countenance was haggard and distressed looking. Appreciating the importance of these unpleasant symptoms at this stage of the disease, the conclusion arrived at was that the time had now come for surgical treatment, so the parents having been made to understand fully the danger to their child and their consent being obtained, etherization of the little patient was soon completed. The urbanity of Dr. Swan caused him to tender to me the honor of operating, which I did in the following manner: Taking the line of direction of Poupart's ligament as my guide, an incision was made parallel with it, two inches in length, commencing about one inch above the anterior superior spinous process of the ilium, the dissection was carefully carried down through the abdominal parietes until the fascia transversalis came to view; this was guardedly opened, and on the withdrawal of the knife from three to three and a half ounces of pus escaped, in which an ordinary sized lady's shoe button was found. Later the patient was asked if she remembered swallowing a shoe button, but she did not. Before dressing the wound the cavity of the abscess was explored, but no further foreign substance of any kind was discovered. The patient made a rapid recovery.

In both of these two cases it seems clear that the disease was caused by the lodgment of foreign bodies in the bowel. As to the proper time for surgical treatment, although operative interference was considerably delayed in both of them (that in the first until the seventeenth, and the last until the twenty-first day) and the results very happy and successful, I think, as a rule, that we should not wait after the first week or ten days before making an exploration with the aspirator, and if pus be found the operation should not be delayed. We should not wait for fluctuation, for often that will not be recognized, even though only the transverse

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alis fascia interpose between the accumulation and our finger. The point of greatest dullness and tenderness, and that will generally be found to be within one inch, more or less, of the anterior superior spinous process, and this is the place that should be first aspirated, and, if pus is not found, very little time should be lost in making a new trial, rather than let our patient run the risk of perforation and death.

In a case near Irvington some years ago, that came under my observation, a young lady who had been threatened with perityphlitic abscess for ten days in which pus was thought to be formed or forming, a delay of forty-eight hours was proposed by Dr. Stephen Weeks, now deceased; but, after waiting almost this time, the patient died with all the symptoms of acute general peritonitis, following, it was thought, perforation. No *post-mortem* examination obtained.

In conclusion, let me say that I think the keeping of the wounds thoroughly opened and drained, together with perfect antiseptics and great care in the dressings, so that no injury be done to the walls of the abscess, which may be very thin and easily ruptured, are points which, if followed, will materially increase the chances of a successful termination of the case.

CREMATION.

WHAT IS THOUGHT OF IT BY PHYSICIANS.

INTERVIEWS WITH PHYSICIANS BY A REPRESENTATIVE OF THE MEDICAL AND SURGICAL REPORTER.

FIFTH SERIES.—NEW YORK—BALTIMORE.

DR. JOHN A. WYETH says: I am fully a believer in cremation of dead bodies. Personally I desire such disposal of my machinery when it is worn out and stops.

DR. T. M. PRUDDEN thinks that cremation as a general method of disposing of the dead is greatly to be desired.

DR. J. R. LEAMING is also in favor of cremation for the disposal of the dead, especially in crowded localities.

DR. OREN D. POMEROY says that he thinks there is no doubt as to the sanitary indications for cremation, rather than burial. The sentiment of the matter, perhaps,

would call for the old method of burial, especially among religious people who firmly believe in the resurrection of the body.

DR. LEWIS A. SAYRE says: In a sanitary point of view, cremation, it seems to me, is the only safe way of disposing of the dead, especially in large cities, and I hope soon to see a law passed that will make it compulsory and universal.

DR. A. MACDONALD is decidedly in favor of cremation, and drew the attention of our Representative to a letter written to the President of the Department of Public Charities and Correction in 1888, in which he urges both the propriety and expediency of substituting cremation for burial in the case of the unclaimed dead of the above department.

BALTIMORE.

DR. H. H. BIEDLER says emphatically that he is in favor of cremation, and is guided in his judgment by sanitary laws, as well as by a desire for the reduction of the corpse into simple elements of a portable bulk.

DR. GEORGE B. REYNOLDS expresses the opinion that cremation should never be permitted in cases of murder, poisoning, suicide, nor when foul play is suspected. Cremation is a good mode of disposing of dead bodies in time of epidemics, wars, floods or whenever the number of dead exceeds the facilities for natural interment. Cremation, in most, if not in all, other cases, should be left optional with relatives or friends of the deceased.

DR. THOMAS SHEARER says: I am strongly in favor of cremation as a means of disposing of human remains, and I am greatly surprised that, from a sanitary point of view, such is not the universal sentiment of the profession.

DR. D. W. CATHELL is of the opinion that cremation is not required, and will never supersede inhumation in this part of the world. I have practiced medicine, he said, for nearly twenty-five years around Baltimore's principal burying-grounds, and have never known a single case of sickness traceable to them. With stinking garbage boxes in every yard; with our germ-producing sewers and our cesspool exhalations; our filthy gutters, our stable effluvia and our market-house debris; with our suburbs alive with disease-breeding slaughter-houses, dumps, pig-styes, manure piles, night-soil-using truck farms; with fertilizer factories, carcasses, weeds,

gullies, stagnant pools and hundreds of other unsanitary foci staring us in the face, with dangers as much greater than inhumation as a camel is larger than a mote, the gain by cremation would be very small. Let us continue to bury our dead, with increased precautions against their affecting the living, and leave cremation to its dreamy partisans and Pagan history.

DR. THOS. B. EVANS says that the cremation of the dead has been to him a subject of thought for some time, and he believes that it is the very best method to pursue. From a sanitary standpoint, it certainly has its advantages, and that is all-sufficient to the medical mind, that labors to prevent as well as to cure disease. I think, says Dr. Evans, that the prevention of disease is the grandest theme which our profession can discuss, and one of the very best means to employ for that purpose, is to incinerate the cause.

DR. GEORGE H. ROHÉ thinks that any agitation in favor of the general adoption of cremation as a method of disposal of the dead would be both premature and unwise. So many directions exist in which medical men can profitably exert their influence for sanitary and other reforms, that he regrets to see activity wasted in pursuit of a chimera. The following conclusions were appended to a paper by Dr. Rohé on this subject, published in the Transactions of the Medical and Chirurgial Faculty of Maryland for 1888. He knows no reason why he should change them now:

"1. Cremation is not necessary as a sanitary measure, under conditions prevalent in this country.

"2. Cremation has no advantage on the score of economy over interment.

"3. Cremation fails to meet the requirements of epidemics or wars so well as burial.

"4. Cremation is objectionable from a legal point of view, as criminal poisoning would often pass undetected if incineration were general.

"5. It fails to comply with the emotional demands of our nature, by substituting a harsh and unseemly procedure for the more poetic and sentimental slow dissolution going on in the grave."

DR. JAMES A. STUART has always approved of the practice of cremation, particularly on sanitary grounds. It will take a long time, he thinks, to overcome popular prejudice, but is glad to add his mite.

DR. HERBERT HARLAN favors cremation

and thinks cremation, as a general method of disposing of the dead, very desirable. He sees but one objection, viz., that if the custom were in general use it could be used as a means of destroying evidence of crime in deaths by poisoning.

DR. HIRAM WOODS stated that he had not given the subject of cremation sufficient thought to make his opinion valuable enough for publication. So far as he had looked into it, however, he could see many things in its favor from hygienic and economic points of view. These seem to him to outweigh the two most potent objections, (1) the possible concealment of crime, and (2) the "sentimental" objections. The prevention of the former will require some care, while common sense will remove the latter.

DR. LEWIS M. EASTMAN was most decided in his opinion on the subject. Life, he said, physical and spiritual, is dear to all. Death affects only the body; and this it makes loathsome and revolting, even to those who loved it most in life. Cremation not only destroys this "hot bed of disease," but permits its elements, at once, to re-enter organic life. For this reason, he also opposes saving the ashes of the dead—let them be scattered over fields,—not of useless and harmful weeds, but useful and food-yielding plants.

DR. CHRISTOPHER JOHNSON expresses his warm approval of cremation for the following reasons:

1. It renders all mortal remains innocuous, and is therefore a great and important sanitary measure, protecting the health of communities.

2. It renders grave robbing impossible.

3. It is a decent and economical mode of disposing of human remains.

4. It anticipates and prevents the painful attempts at the removal of human remains when succeeding generations demand the space they occupy for the needs of growing cities.

5. The possibility that in a small number of cases the evidences of crime can be destroyed by cremation ought not to outweigh the great benefits conferred by the destruction of the germs of death which menace the living by polluting the air of graveyards, especially near the large cities, and the air of those cities themselves.

DR. EDWARD M. HARTWELL, of the Johns Hopkins University, was next questioned. He said it seems to him that cremation affords the safest and best means, from a

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scientific and sanitary point of view, for the general disposal of dead bodies; but popular prepossessions, grounded on sentimentality and superstition, in favor of coffins and inhumation, are so deep and strong that he sees little prospect that cremation will become either popular or usual, in America, in our day.

According to DR. CHAS. C. BOMBAUGH, the chief argument in favor of cremation is the all-important one of sanitation. In and around large cities, where every foot of ground is needed for the accommodation of a superabundant population, it avoids the overcrowding of cemeteries, and thereby prevents eventual contamination of air and water. In these days of progressive improvement its advocates contend that a lingering sentiment must give way to science, and the religious aspect of the question must yield to the sanitary aspect. With regard to the Christian view of the resurrection of the body, they consider it immaterial whether it moulders into dust, or is converted into ashes. The most weighty argument against cremation is that of medical jurisprudence. In cases where subsequent appearances or discoveries create suspicion of criminal poisoning for the accomplishment of atrocious purposes, if the body is destroyed by fire, the anatomical and chemical evidence, and hence the means of positive detection, are destroyed with it. In the summation of testimony, much, of course, depends on the moral evidence derived from the surroundings, the non-medical facts which the physician, as well as other persons concerned, must weigh and measure. But the clinching witness is to be found in *post-mortem* analysis and demonstration, and those who are familiar with the statistics of crime and the large ratio of poisoning in every country, have good reason to fear that if cremation were to become general, a considerable proportion of murderers of the Borgia school would escape capital punishment.

DR. T. BARTON BRUNE regards cremation as the most desirable method of disposing of our dead. To him the only objection to it is a sentimental one; but this, unfortunately, is so popularly held that a long time and great perseverance on the part of its advocates will be needed to insure the general adoption of cremation. Perhaps the knowledge that the horrors of premature burial and of the resurrectionist are prevented by cremation may commend it to the sentimental public.

DR. WILMER BRINTON has no decided views in regard to the propriety or desirability of cremation. He recognizes, however, that under certain circumstances cremation is the most rational method of disposing of the dead, and believes that at some future time it will become popular in all the large cities of our own and other countries.

DR. T. A. ASHBY says that from a hygienic and sanitary standpoint cremation is the only rational method of disposing of the dead in large communities. Its practice should be enforced by the State in times of war, pestilence and epidemic. As the method of burial of the dead is sustained chiefly by custom and sentiment, it is possible to educate society up to the point of considering the great advantages of cremation in the interest of the living. With the rapid growth of population in the United States and the increasing tendency to concentrate this population in large communities, the time has come for a general movement of all classes of citizens in favor of cremation.

DR. SAMUEL THEOBALD has long felt that the disposal of the dead by cremation is far preferable to the semi-preservation of the body by burial; and this is true, he thinks, whether we regard the matter from a hygienic or from a sentimental standpoint.

DR. J. H. HARTMAN unhesitatingly says that he regards cremation as the only proper and sanitary method of disposing of the dead.

DR. CHAS. E. SADTLER thinks that for the large cities of modern times, with their frequent epidemics, the "decay and worm" method of disposing of the dead is a source of danger to the living, and he is entirely in sympathy with any concerted movement towards cremation.

DR. WALTER B. PLATT considers the cremation of human dead bodies eminently proper and desirable, on sanitary as well as on economic grounds.

DR. J. E. MICHAEL confesses having given the subject of cremation very little attention. Personally he is entirely unprejudiced, and sees no objection to its being carried out when desired and when there is no mystery about the cause of death; but if it is generally adopted it will be necessary to attend to the matter of death certificates much more accurately and thoroughly than is done at present, or much crime which is now detectable by *post-mortem* examination and chemical analysis will go unpunished.

Viewing cremation from a sanitary standpoint, DR. R. W. MANSFIELD thinks it best for the living, and it should therefore be more generally adopted.

DR. F. T. MILES thinks cremation will be the mode of disposing of the dead in the future. This will be demanded by the micro-organism theory of the propagation of disease.

DR. I. R. UHLER is, for sanitary reasons, highly in favor of cremation; as heat is the best disinfectant, and, after death from contagious diseases, it should always be promptly employed. From a medico-legal standpoint I am opposed to cremation, as it affords an opportunity to get rid of evidence, especially in poisoning and life insurance cases. For the same reason I object to embalming by poisonous substances and think for the present it is better to use the ice casket.

DR. JOSEPH T. SMITH says that his mind has been made up in favor of cremation for several years. He sees nothing but what is eminently proper in thus, in a clean, orderly manner, rapidly disposing of the body. So long as the return to dust cannot be prevented, the proper thing, it seems to him, is to hasten this return of the body to its natural elements by all the means in our power. Nature herself takes, I think, the proper course, and at death begins at once with her micro-organisms a rapid destruction of the body. I think cremation desirable in that it removes one great source of infection of the earth's surface. This alone I think sufficient to render it desirable that all diseased bodies should be destroyed by heat, in order that there shall be no possibility of their infecting the ground of the living.

DR. W. T. COUNCILMAN sees no objection to cremation.

Scientifically, DR. RANDOLPH WINSLOW believes that cremation is the best method of disposing of the dead, but he must confess to a certain amount of repugnance to it, practically.

DR. N. G. KEIRLE's opinion is that from a hygienic and æsthetic point of view, cremation is more desirable than the present mode of disposal of the dead, which is an expression of emotion wrongly fashioned. Cremation, of course, should be subject to legal and medical restriction.

DR. J. C. HEMMETER states that he is emphatically in favor of cremation. By explaining its method and advantages to the populace it cannot help but meet with gen-

eral approval. It is certainly a more pleasing thought to have one's body return to its primitive elements at once, than to have it rotted and corroded by various chemical fluids and animal forms. Besides, it is very probable that cemeteries act as sources of wholesale infection. To the great majority that constitutes the middle class of our people, cremation is more economical than burial; funerals have become very expensive ceremonies—this should not be overlooked.

DR. J. D. IGLEHART holds cremation both proper and desirable from a hygienic point, for all large cities; but the popular mind will have to be educated before it can be looked upon as a satisfactory substitute for the prevailing custom.

DR. JOHN F. MONMONIER does not see the desirability or the propriety of changing the present mode of disposing of the dead for that of cremation. In the distant future it may become necessary to resort to a system of general cremation as a sanitary measure.

DR. J. MASON HUNDLEY opines that cremation offers many advantages over the more ordinary method of disposing of the dead, especially in large cities; but the idea is revolting to many, and it will require time—if ever it can be done—to educate the people in adopting it universally.

DR. J. M. CORTUL says that cremation meets with her approval. She thinks it the best manner of disposing of the dead in our large cities. It not only improves the sanitary condition, but according to her judgment, would materially assist in beautifying our cities and suburbs, by doing away with cemeteries, which give a gloomy appearance, no matter how beautifully arranged.

DR. W. WINSEY says that the propriety and the desirability of cremation, instead of inhumation as at present generally practiced among us, must, for many years to come, in a country like ours, remain a matter of individual feeling and inclination. He thinks the conditions in this country, with few exceptions, are not such as to call for legislation upon the matter, in the absence of which the change of opinion in favor of cremation will be very gradual. Personally he would not object to having his body cremated.

DR. EUGENE F. CORDELL is heartily in favor of cremation. The interests of the living have not been given their due weight in the consideration of the subject, which has further been obscured by too much sentiment-

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ality. In his opinion the demands of modern sanitary science can be met only by cremation. None of the objections to it seem to deserve any consideration except that it may sometimes be an obstacle to the detection of crime, and with proper safeguards even this objection may be practically done away with.

DR. HENRY M. HURD says there are, in his judgment, grave objections to cremation from a medico-legal standpoint, which far outweigh its advantages from an hygienic point of view. Until population in America is denser and the lack of ground for burial purposes is more pressing he does not think it desirable to adopt cremation as a general means of disposing of the dead.

DR. R. L. RANDOLPH says the cemetery system is bound to be a temporary one. Burning does quickly what it takes putrefaction a long time to accomplish, and from a sanitary point of view the former is infinitely preferable.

DR. B. F. LEONARD thinks that in this comparatively young country cremation is not yet a burning question; but it has everything to recommend it. It is sanitary, it is cheap; it robs the tomb of its foulness and danger to health by inoffensively accomplishing a quick return to the elements; and to a reflecting mind it cannot arouse religious prejudice or legal objection, as there is ample opportunity to pay proper respect to the dead, and to investigate suspicious cases of death.

DR. EDWARD E. MACKENZIE thinks well of cremation, and trusts the time may come when all may think the same.

DR. A. FRIEDENWALD is opposed to cremation on the ground that the objections that have been made against interment for sanitary reasons have not been satisfactorily established.

DR. W. D. BOOKER is inclined to the opinion that cremation is the best method of disposing of the dead.

DR. P. C. WILLIAMS says: My opinion on the subject of cremation is this:

There are three aspects under which it presents itself: 1. Its religious aspect. "Dust thou art, and unto dust shalt thou return." It certainly makes no difference whether we return to dust through the rapid process of fire, or the slow process of natural decay.

2. Its appeal to one's feelings. Some shrink from the idea of our direct agency in committing our dear ones to the flames; but is the agency not equally direct if we

commit our friends to the dust or to the waves, if they should have to be buried at sea?

3. It presents the question of healthfulness. This is the clearest and strongest of all grounds upon which we can consider the question of cremation. When we see how rapidly all the cemeteries near our large cities are filling up, it becomes a serious question not only where space can be had for the burial of the unnumbered thousands that must be disposed of during coming generations; but it becomes a still more serious question how this innumerable collection of dead bodies may affect the health of our cities. On both these grounds it seems to me that sooner or later we will be driven to cremation as the only possible solution of a rapidly increasing difficulty. If it must come to this ultimately, why not begin at once? When an act becomes inevitable the sooner it is done the better! Therefore, upon grounds of religion or ethics I see no objection; upon grounds of healthfulness there is not only no objection, but to my mind there will soon arise urgent necessity for cremation.

EXTERNAL PERINEAL URETHOTOMY.—REPORT OF CASE.

BY T. G. HICKMAN, M. D.,

VANDALIA, ILL.

George B., 30 years old, consulted me in March, 1888, for a difficulty in voiding his urine in the natural way, telling me that the most of it passed underneath through "holes" and that matter ran out through the holes all the time. He gave the history of an injury he had received eighteen months before, stating that while walking on the comb of a house, his feet slipped and he fell astride the comb, with all his weight coming upon the genital organs.

On examination I found three fistulous openings in the perineum, with evidence of a discharge of purulent matter.

An attempt to introduce an instrument of any size into the bladder failed. A bougie of large size could be easily passed as far as the bulbous portion of the urethra, but then met with obstruction. The smallest size flexible metal sound could not be passed beyond this point. A small probe was passed

through the largest external fistula for a distance of three and one-half inches, when it came in contact with the metal sound that had been passed to the seat of obstruction. The touch of the two instruments could be distinctly felt.

I informed him, that in order to be relieved, a surgical operation would have to be performed; and that I could not say positively that it would be a success, but that it was his only chance to be relieved.

The patient expressed his willingness to have it done. But when the time for the operation came he did not put in an appearance.

The next thing that I heard was that he had fallen into the hands of another "physician" who had offered to cure him in two weeks, without an operation; and that the cure was to be effected with salve alone. This easy mode of treatment, and the short time it would take to be cured, had the effect of taking him out of my hands for a time. After several weeks of salve treatment without any benefit, and having exhausted his ready stock of cash in traveling back and forth on the trains, he came to me again in November, 1888, and wanted me to take his case. As he lived seven miles in the country, I told him if I took his case he must come to town. This he agreed to do, and moved in. On examination, I found the same conditions existing as in March before. On the 4th of December, accompanied by Dr. F. B. Haller and two assistants, I went to the house he had rented, which was a miserable, little, poorly lighted room; very unsuitable for an operation requiring light.

The patient was placed in the dorsal lithotomy position, and chloroform was administered by Dr. Haller, until stertorous breathing was produced, and, as we supposed, anaesthesia complete. The Doctor now introduced the grooved staff as far as the obstruction. I now attempted to make an incision, but on the slightest touch of the knife, it was evident that sensibility was too great to proceed.

The chloroform was then pushed as far as safety would allow, and another attempt was made to proceed; but such was the refractory and unmanageable condition of the patient, that owing to the lateness of the hour, our already exhausted stock of chloroform and the need of more assistants, it was deemed advisable to postpone the operation for two days.

On the 6th of December, having procured three additional assistants, now five in all, the patient was placed in same position, chloroform administered by Dr. Haller until the breathing became stertorous. The chloroform was now entrusted to an intelligent young man who had assisted me on several occasions.

The staff being introduced, I now commenced the incision, but sensibility was still so great, that it required the united efforts of all the assistants to hold the patient still enough to use the knife with any certainty. An incision was made in the median line $1\frac{1}{2}$ inches long, and gradually deepened until the groove in the staff could be felt with the point of the knife. With a few forward cuts with the point of a curved bistoury, Dr. Haller was enabled to advance the point of the staff a little. At this juncture I resorted to the use of a wire guide I had improvised, in the absence of the whale-bone bougie. The wire guide with bulbous point was now pushed backwards in the groove through the end of staff, until it entered the bladder.

The urethra being deep and the incision short, necessitated the use of two ligatures, which were deeply inserted into the edges of the incision, and the wound held apart by two assistants, making traction on the ligatures.

The point of the staff could now be felt with the index finger, as could also the urethra in front of the prostate glands. With a curved pointed bistoury, the point held well up to the roof of the urethra, the incision was carried backwards, and the staff advanced at the same time over the wire guide, until the end of the staff entered the bladder, which it did easily, and was rotated. This completed the operation. The patient was placed in bed; an opiate left to be taken when consciousness returned.

The after treatment consisted of daily washing out the bladder with antiseptic solutions. The catheter was left out during the night, but inserted each morning. This treatment was continued for five weeks, when patient wanted to go home. I had him to report every third day for two weeks, then once a week for three or four weeks, when he continued same treatment at home by means of a funnel attached to the rubber tube. There has never been any recontraction of the caliber of the urethra, and the expulsive force of the bladder appears to be as strong as ever. I also learned, through

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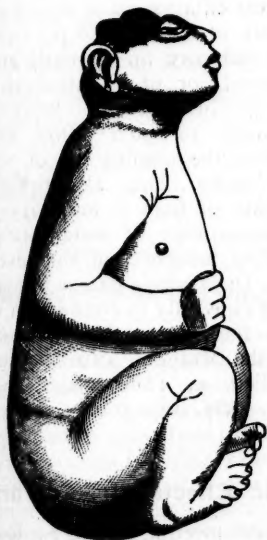
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A PSEUDOCEPHALOID INFANT.

BY W. W. PENNELL, M. D.,
FREDERICKTOWN, OHIO.



The accompanying photograph, copied from a hand-made picture of a monstrosity born Nov. 5, 1889, is quite accurate. The father and mother of the child were white. The mother, Mrs. S. D., healthy, 39 years old, is the mother of six well-formed children, two of which are dead. The birth of this child was natural, vertex presentation in the second position; sex female; weight nine pounds; natural respiration was established immediately, the pulsation being strong and regular. By a sharp noise, or by touch, the infant was thrown into prolonged clonic convulsions, during which it became cyanotic and frothed at the mouth. Nursing could not be induced and feeding caused excessive strangling and convulsions. The eyes remained open, becoming dry and bleary.

This monster lived seventy hours, never crying nor swallowing nourishment, and lost flesh rapidly. The bowels moved but once; the kidneys remaining inactive. An examination was made after death, showing perfect development of every part except

the head. The frontal, parietal and the greater portions of the nasal, temporal and occipital bones were absent. The eyes, resting upon the floor of the orbit, gave the face a frog-like appearance; the scalp drawn over the edges of the remaining cranial bones, was constricted as by a band just over the foramen magnum, where it was perforated by a dark red fungoid mass, apparently an undeveloped eucephalon, and covered by a membrane resembling the pia mater. This mass weighed two ounces, and contained five separate sacs filled with a serous material, the largest sac being adjacent to the foramen magnum. The remainder of the mass was made up of blood-vessels and connective tissue.

Portions of brain substance were found in depressions laterally and anteriorly to the foramen magnum joined by a bridge or pons. This material seemed to be cerebellar and medullar, and did not exceed two drachms in weight. Dissection of one eye showed it to be normal, except the direction of the optic nerve, which was through the body of the sphenoid into the basilar process, and it emerged near the foramen magnum into the substances surrounding that opening. The chief interest herein is that the child was carried to full term, the mother having menstruated last about January 16, 1889,—and in the difference of the kind of movement experienced from that of her other children; the motions of this monstrosity consisting in an intermittent, spasmodic and strange jerking movement, increased or prolonged by exercise or by jarring.

PERISCOPE.

An Unusual Case of Pneumonia.

Dr. Wm. Porter, Jr., of Hartford, Conn., reports in the *Boston Medical and Surgical Journal*, Dec. 26, 1889, the following interesting case: A prominent judge and lawyer, in somewhat reduced health from overwork, was taken with a severe chill at his office, October 1, 1888. Evening temperature 103° , with intense headache as the only other symptom of importance. The following morning a circumscribed pneumonia was located in the right lung. During the following week the symptoms were favorable, but it was then found that resolution was not taking place, but instead, the disease was slowly spreading toward the apex.

From this time until the third week in November, the history of this case is one of succeeding attacks, some severe, others slight, until the disease had extended entirely over both lungs, including the apices. Each exacerbation was accompanied by a rise of temperature, though at no time was it as high as that following the initial chill. The examinations of the lungs during those weeks were most interesting, showing areas of consolidated tissue, with surrounding tracts in the various stages of resolution.

The treatment was largely expectant, quinine, iron and the iodides being used as seemed indicated; the most careful attention being constantly given to the nourishment and the state of the digestive organs. Large amounts of milk, and the strongest beef preparations were well borne, and stimulants were used in increasing amounts, but with every help, weakness increased, the weak heart so characteristic of pneumonia being fully developed, and the danger of fatal heart failure imminent. At this time inhalations of oxygen and nitrogen monoxide were begun, and proved of great value. The inhalations were continued for three to five minutes, and repeated every hour, or two or three hours, as seemed needed. The effect of each inhalation was most grateful to the patient, giving a sense of refreshment in marked contrast to the extreme weakness that was present. It was a conscious aid during the progress of digestion. The action of the heart was improved, the pulse being stronger and more regular for some time after each inhalation; and as the days passed, it became evident that the lungs were clearing up more rapidly. Three cylinders of the gas were used, its value in conditions of extreme debility and heart weakness, as well as in cases where dyspnoea and cyanosis are present, being fully demonstrated.

On the Influence of Water on Respiratory Gaseous Changes.

At the Third General Meeting of Russian Medical Men at St. Petersburg, Dr. I. I. Tüvim communicated the results of his experimental inquiry into the action of drinking water on the respiratory gaseous changes in animals subjected to starvation. The experiments, forty in number, were conducted (in Professor V. V. Pashutin's laboratory) on young dogs weighing from 5 to

10 kilogrammes. The results (see *Transactions of the Meeting*, 1889, No. 10, p. 338) may be briefly given thus: 1. When introduced into the animal's stomach in doses less than 100 grammes per kilo of the body's weight, water does not manifest any appreciable influence either on the elimination of CO_2 and aqueous vapors, or on the absorption of oxygen. 2. When injected in doses of 100 grammes to each kilo, water increases the elimination of aqueous vapors (at the rate of from 2 to 8 per cent.), but shows no influence on the daily amount of CO_2 excreted, or of O absorbed by the lungs. 3. In doses of from 150 to 200 grammes to each kilo, water increases both the elimination of CO_2 and aqueous vapors, and absorption of O (at the rate of from 5 to 20 per cent.). 4. The temperature of water injected has but a trifling influence on the changes in question. Dr. Tüvim's statement may prove interesting especially in connection with the papers on the therapeutics of water, published in the *MEDICAL AND SURGICAL REPORTER*, Feb. 9, 1889, page 175, and March 23, 1889, page 360.

Toxic Effects of Antifebrin.

At a recent meeting of the Sophia Medical Society, Dr. Khakanoff has related an instance of accidental poisoning by antifebrin (*Meditsinski Pregled* [a Bulgarian periodical] Nos. 1 and 2, 1889, p. 24). A lady who had been in the habit to take 15-grain doses of antipyrin on account of some menstrual neuralgic pains, on one occasion tried to treat herself, without consulting any doctor, with antifebrin in the same doses. Accordingly, she took 15 grains of the drug at bedtime and another dose the next morning. The first powder caused no inconvenience, but the second was almost immediately followed by extreme malaise, intense cyanosis, cooling down of the whole body, difficult breathing, irregular and hardly perceptible pulse, and twitchings about the face and body. The skin remained dry. Under the influence of various stimulants and analeptics (including heat), the symptoms gradually subsided. During the evening, a profuse diuresis followed. By the next morning her condition had returned to normal. Dr. Khakanoff draws attention that in some patients antifebrin gives rise to profuse perspiration.

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while in others (as in the case above) it causes profuse diuresis. Referring to the paper, Dr. Molloff, of Sophia, says that he personally has seen two cases of toxic symptoms produced by 7-grain doses of anti-febrin. In both of them (one referring to a child, the other to an adult who had taken four doses at the interval of an hour) the symptoms consisted in the phenomena of collapse and rapidly yielded to stimulants.

Tape-worm Remedy.

The following should be taken in one dose before breakfast :

R Ol. tiglli	gtt.j
Chloroformi	f ʒj
Glycerini	f ʒj

Venesection in Chlorosis.

The practice of venesection in chlorosis would not at first sight appear likely to yield good results, but that it is capable of acting most beneficially is vouched for by Dr. Wilhelmi, who has for some time past employed it with great success in typical cases of chlorosis. About three or four ounces of blood only should be taken, the patient being in bed and being covered up with blankets and plied with hot drinks until sweating comes on. It would appear that the severer the case the more benefit may be expected from the bleeding, but that this treatment is of little use in mere hysterical or symptomatic anemia.—*Lancet*, Dec. 21, 1889.

Tubercular Disease of the Eye.

Like all comparatively rare diseases, cases of primary intra-ocular tubercle may give rise to considerable doubt in the minds of those under whose care they are, both as regards diagnosis and treatment. In certain instances it is next to impossible to distinguish between tubercular and syphilitic nodular iritis; yet in reference to the adoption of active treatment a correct diagnosis is all-important. Such doubtful cases have been described on several occasions as granuloma of the iris, a name which is said by some authors to signify that the disease is of syphilitic origin, while others hold that it is tubercular. At the best it probably means that our knowledge of such bases is not yet

complete. The doubts which arise regarding treatment chiefly concern operative measures. If the disease be tubercular, should the eye be excised, in the hope of removing a centre of infection, and thus preventing general tuberculosis? If syphilitic in nature, active antisyphilitic treatment is indicated, and these measures would but doubtfully conduce to the cure of tubercle. The records of cases seem to point to enucleation as the best treatment for primary intra-ocular tubercle; on the other hand, in a certain number of cases recovery has ensued from disease which had all the clinical characters of tubercular iritis. One point seems fairly well established, viz., that if any operation is undertaken it should be removal of the entire globe; iridectomy performed with the intention of removing the diseased portion of iris has been almost uniformly unsuccessful.—*British Med. Journal*, Dec. 21, 1889.

Creoline in Erysipelas.

The antiseptic and innoxious properties of creoline have suggested its use as an application in erysipelas. As such, it has given excellent results both in Austria and Germany. The preparation may be employed alone or with iodoform. An agreeable form is the following salve :

R Creolini	℥ xxxviiiij.
Lanolini	ʒ vjss.

M. et fiat unguentum.

Sig. Apply the salve so as to cover the erysipelatous surface and overlap it about one-half inch on all sides.

The affected parts should further be protected with a piece of mackintosh or protective.

If the addition of iodoform is desired the following prescription will be found efficacious :

R Creolini	f ʒss.
Iodoformi	ʒ ij.
Lanolini	ʒ xx

M. et fiat unguentum.

Sig. Use similarly to former salve.

This preparation is more active than the plain creoline salve. When hairy portions of the body are affected it is well to shave such before applying the ointment. The treatment should be continued for three or four days after the disease has ceased to spread.—*Gazette Hebdomadaire*, Nov. 15, 1889.

Infantile Dyspepsia.

Dr. Le Gendre, in the *Concours Médicale*, Nov. 26, 1889, speaks most highly of value of papaine and lactic acid in the dyspepsia of very young infants. He uses the following prescription with great success:

R Papaini gr. viij
Acid. lactici gr. xxxj
Syrupi simpl. f ʒ iiij
Aque dest. f ʒ v
Tinctur. vanillæ q. s.

M. Sig.: A small teaspoonful immediately after each feeding and every intervening hour.

Vaseline Cerate.

The following is an excellent formula for vaseline cerate:

R Vaselini albi ʒ xvj
Ol. amygdaliæ dulce f ʒ jss
Cereæ albæ ʒ jss

Melt this mixture at a gentle heat, incorporate in a warm mortar and gradually add one and one-half ounces of rose water. For vaseline cold cream, replace the wax with an equal quantity of spermaceti and add perfume as desired.—*Journal de Méd.*, Nov. 24, 1889.

Treatment of Coryza.

Mr. James McMunn, in the *British Med. Journal*, Dec. 14, 1889, states that for many years he has found the following combination most efficacious in the treatment of cold in the head:

Salicylic acid, 4 parts.
Tannic acid, 6 "
Subnitrate of bismuth, 90 "

The Subcutaneous Administration of Iron.

Professor Rosenthal, of Vienna, writing in a Pesth medical journal on the subcutaneous administration of iron, states that this method is advantageous in the cases of delicate neurasthenic persons who suffer, as such often do, from atonic dyspepsia. Here even small doses of iron taken by the mouth will sometimes produce disorder of the stomach. In severer forms of disease, such as pernicious anemia, malaria cachexia, and the graver forms of leukemia, there does not appear to be any advantage in the employment of the hypodermic method of administering iron. Two new preparations are recom-

mended by Professor Rosenthal for hypodermic use—viz., the peptonate and the oleate of iron. He states that he has never seen any bad results follow subcutaneous injections of iron preparations, and he explains the fatal consequences that have occasionally been reported as following injections into vascular tumors of the head, by the fact that the vessels composing such tumors are generally closely connected with the veins of the dura mater. He has frequently seen venous enlargements of the legs undergo shrinking after being injected with dilute perchloride of iron, no dangerous symptoms ever ensuing.—*Lancet*, Dec. 14, 1889.

Healing Salve.

The following salve will be found a useful application for chapped lips and slight abrasions:

R Boric acid 2 parts
Vaselin 30 "
Glycerin 3 "

M.

The above may be perfumed by the addition of a few drops of attar of roses, if intended for a lip salve.

Codeine.

Codeine being but slightly soluble in water, is best given in pill or powder form or in solution in alcohol and syrup. The following prescriptions for the drug are recommended by Dr. Kaufmann in the *Berliner klin. Wochenschr.*, Nov. 4, 1889:

I. Codeine Pills.

R Codeini gr xv
Extr. gentian,
Pulv. rad. liquir aa q s.
f. pil. No. xxx.

II. Codeine Mixture.

R Codeini gr iij
Alcoholi f ʒ jss
Syrupi f ʒ iijs

M. Sig. One teaspoonful to one tablespoonful for one dose.

When given hypodermically the murate or phosphate of codeine should be used, as either of these salts are easily soluble in water. The average dose for codeine is $\frac{1}{4}$ grain, or three grains daily.

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

MENSTRUATION AND PSEUDO-MENSTRUATION AFTER DOUBLE OVARIOTOMY, AND REMOVAL OF THE UTERINE APPENDAGES.

One of the most interesting phenomena which sometimes follows double ovariectomy, or removal of the uterine appendages, is the persistence of menstruation, or a more or less periodical metro-staxis. This is usually utterly unexpected to the patient, and may cause her to lose some of her faith in medicine as a science, or in the operator as a successful practitioner. The phenomenon is also of interest to the physician because of the physiological and pathological questions involved. That the occurrence is not very rare may be seen from the fact that statistics seem to show that from five to ten per cent. of women who have submitted to double ovariectomy, or the removal of the uterine

appendages, afterward go through the phenomena of menstruation or pseudo-menstruation. Wylie gives ten per cent. as the number; Battey four cases out of fifty-four.

As to the causes of this persistent bleeding there is a general agreement among operators; and it is attributed either to leaving behind some portion of ovarian tissue, or to certain diseased conditions in the pelvic peritoneum, blood-vessels and connective tissues, or to disease of the uterus. Theoretically it is possible always to remove the uterine appendages entire, but in practice it is at times exceedingly difficult. Even though the ovary is freed sufficiently to pass the ligature below it, it is sometimes necessary to "scalp" the ovary to leave a stump sufficiently good to prevent the ligature from slipping. Also in enucleating ovaries densely adherent to the floor of the pelvis, the ovarian tissue is at times torn, and portions are left behind. Besides this, ovarian tissue may remain in the form of supernumerary ovaries, which exist with sufficient frequency to require consideration.

Menstruation may or may not continue when ovarian tissue is left—this depending largely on the nature of the blood-supply to the ovarian tissue.

Hegar states that incomplete extirpation of the ovaries, and the presence of a third ovary are less frequently the cause of recurring hemorrhages following operation than is generally believed. A greater influence is exerted by vascular dilatations, stasis and hyperemia of the pelvis, such as are often present before operation or may develop later. More pronounced pathological processes, such as inflammation of the pedicle, ligaments, other parts of the pelvic peritoneum, and connective tissue, and tuberculosis, produce periodical or irregular hemorrhages, partly by a direct influence on the circulation, partly by nervous agency. Ols-hausen agrees, substantially, with this view, but considers that the most frequent cause of pseudo-menstruation after operation is the persistence of pelvic inflammation, espe-

cially if more acute inflammation or abscesses develop.

Persistent uterine hemorrhage is at times due to uterine disease, such as adenoid growths in the endometrium, fibroid tumors—especially of the submucous variety,—polypi, or malignant degeneration.

Several practical conclusions are to be drawn from these well ascertained facts. As it is by no means positive that the complete menopause will be established, after double ovariectomy, or the removal of the uterine appendages, patients undergoing such operations—or certainly near friends of the patients—should be told so plainly. Under existing circumstances the operator should feel only relatively disappointed when a complete menopause does not result after the double operation; and should set himself diligently to work to cure the particular morbid condition which is causing pelvic and uterine congestion. In the exceptional cases, in which the ovaries have not been entirely removed, or in which supernumerary ovaries exist, and true menstruation continues, a second operation and exsection of the remaining ovarian tissue may be necessary. Also, when infection of the pedicle causes abscess about the ligature, it may be necessary to evacuate the pus and remove the ligature by secondary abdominal section. More commonly, in cases which have been drained, pus is discharged through the drainage track until the ligature comes away or is removed. Pus formation about the ligature does not occur so frequently in cases which have not been drained, largely for the reason that death is likely to take place in these cases, from sepsis or peritonitis, before abscess results. Where the recurring metrorrhagia is due to uterine disease, thorough curetting of the endometrium may suffice to cure it. When malignant degeneration of the womb exists, hysterectomy, or exsection of the degenerated tissues is indicated.

The production of essential oil of geranium in the island of Re-union in the Indian Ocean is assuming considerable proportions.

SNAKE BITES.

There is perhaps no member of the animal kingdom which is so grossly misjudged and misunderstood as the snake. Popular fallacies concerning the snake are very numerous, even among well-informed people. There is a widespread idea that snakes are slimy creatures capable of springing great distances. In truth, the snake is smooth and dry and cannot spring further than two-thirds of its own length. Again, the pugnacity of the snake is greatly overrated. Non-poisonous snakes are most timid, and will scurry out of sight as soon as they are discovered. Poisonous snakes are, as a rule, more sluggish; and when disturbed, or hurt, will generally show fight. Careful inquiry of persons who have been bitten by reptiles will, however, elicit the fact that they either stepped upon, hurt, or surprised the animal that injured them. Stories of snakes chasing people for long distances are of very questionable veracity.

There are two questions which are frequently asked by travelers in countries where snakes abound: first, how can one tell the difference between the bite of a poisonous and that of a non-poisonous snake? Second, what is the best immediate action if bitten by a poisonous reptile, and far away from medical attendance?

The first question is easily answered. Poisonous snakes bite, and then let go; non-poisonous snakes retain their hold. The wound inflicted by a poisonous snake is very slight, and consists merely of two fang punctures, thus: . . .

On account of its apparent insignificance it is frequently referred to as a "sting." The wound inflicted by non-poisonous snakes is much more severe, and would look something like this: . . .

As the short, but lance-like, teeth of harmless snakes are set backwards in the jaw, they become caught in the wound, and, if the victim pulls the reptile forcibly away, his flesh is torn and an ugly laceration is

inflicted. Still, such a wound heals wonderfully quickly and without any unpleasant symptoms. Another, and almost distinctive feature between poisonous and harmless snakes is their form and appearance. Harmless snakes are generally slim and bright in color; whereas poisonous ones are thicker, heavier looking, and more neutral in hue, and are frequently mistaken for twigs or small branches when lying in the road.

Regarding the treatment of snake bites a great deal has been said and written. In the *REPORTER*, July 20, 1889, Dr. L. J. Jones, of Moscow, Mo., in an article on this subject refers to the so-called "Bibron's antidote," a mixture of iodide of potassium, corrosive sublimate and bromine. Although excellent results are said to have been obtained with this mixture, Dr. Weir Mitchell regards them as apochryphal and the remedy as worthless. Again in the *REPORTER* for July 23, 1889, Dr. C. R. Early, of Ridgway, Pa., writes of the efficacy of pure olive oil. Lately, also, the hypodermic use of a weak solution of carbolic acid injected directly into the punctures has been spoken most highly of.

Whatever the vaunted efficacy of these and other antidotes may be, it is seldom that they are at hand at the time of the bite, and the necessity for immediate action is most evident. Regarding the best procedure in such cases, if far away from help, Dr. S. Weir Mitchell, in an article entitled "The Poison of Serpents," in the *Century*, August, 1889, says: "If the wound be at the tip of a finger, I should like to get rid of the part by some such prompt auto-surgical means as a knife or a possible hot iron affords. Failing these, or while seeking help, it is wise to quarantine the poison by two ligatures drawn tight enough to stop all circulation." Dr. Mitchell further says that, on account of the heart weakness, which is made worse by emotion, the patient may need some stimulus to enable him to get home, and that as soon as possible some one should thoroughly infiltrate the

seat of the bite with permanganate or some other agent. By working and kneading the tissues the venom and the antidote may be made to come into contact, and the former be destroyed.

To our mind, courage shows itself in the wrong direction, in chopping off the bitten finger or toe; which is a very foolish and dangerous proceeding. The most sensible and most efficacious procedure seems to be as follows: Immediately after having been bitten, and after convincing one's self that the bite is that of a poisonous snake, tie one or two tight ligatures at some distance above the punctures. For this purpose a string or cord tied loosely around the finger or a handkerchief tied around the arm, and then twisted up tightly with the aid of a small stick, answers admirably. Then thoroughly lacerate the wound, fully as deep as the punctures, with a knife or a sharp stone. Wash the parts with water or, in an emergency, with urine. Keep moving, and do not despond. The ligature should be loosened in about fifteen minutes to prevent gangrene but may again be tightened until help is obtained. On reaching home, a stiff glass of hot whiskey or rum-punch should be taken, or any other stimulus, if this is not at hand. The subsequent treatment depends upon circumstances. In the majority of cases stimulants and rest are all that is needed. Locally, hot fomentations or poultices may be applied. If necessary, carbolic acid solution or other antidotes should be injected into the wounds; this is, however, rarely required.

THE DURATION OF A LIGHTNING-FLASH.

—The researches of Trouvelot, Colladon, and Dufour have shown that the duration of a lightning-flash is not infinitesimal, but that the flash lasts a measurable time. For instance: if one sets a camera in rapid vibration, and exposes in it a plate so as to receive the impression of the flash, it is found that the impressions appear widened out on the negative, showing the negative to have moved during the time the flash was in existence.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the *REPORTER*.]

INTRODUCTION TO THE TREATMENT OF DISEASE BY GALVANISM. By SKENE KEITH, M. B., F. R. C. S. ED., Late Special Assistant Surgeon, Royal Infirmary, Edinburgh. 8vo, pp. 62. London: Truslove and Shirley, 1889. Price, \$1.25.

The author modestly states that this book is intended only for those who have no time, and perhaps no inclination, to study larger works on the use of electricity in the treatment of disease. He discusses in simple language various electrical phenomena, and also the laws of electricity which have a special bearing upon the use of the galvanic current in therapeutics. The book is well and plainly written, and the uninformed reader will undoubtedly derive much information from it; and perhaps be stimulated to study more comprehensive treatises. In connection with this book it is interesting to note that the author's father, Thomas Keith, one of the most accomplished abdominal surgeons now living, and one whose successful operations of hysterectomy have never been equaled, gives Apostoli's method of treatment the preference over cutting operations, as the primary method of treatment for fibroid tumors of the womb.

A GUIDE TO THE DISEASES OF CHILDREN. By JAMES FREDERIC GOODHART, M. D., F. R. C. P., Physician to Guy's Hospital, and to the Evelina Hospital for Sick Children, etc. Rearranged, revised and edited by Louis Starr, M. D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc. Second American, from the third English edition, with numerous formulae and illustrations. 8vo, pp. 772. Philadelphia: P. Blakiston, Sons & Co. Price, Calf, \$3.00; Sheep, \$3.50.

Goodhart's "Diseases of Children" has been very favorably known in this country for several years, partly because of the great merit of the book itself, and partly because of the excellent reputation enjoyed by its American editor, Dr. Starr. In the third English edition—from which this second American has been made—Dr. Goodhart had thoroughly revised the book, but had not materially altered it. He has, however, endeavored to make it more useful to the student and young practitioner by amplifying the directions relating to diet in infancy—unquestionably a subject of the highest importance, and generally by inserting, where it has been deemed possible, such recent methods of treatment as have either proved, or promise to be, successful. The American editor, on the other hand, has taken greater liberties with the book than he did in his previous edition. He has rearranged the original matter so as to secure greater symmetry and ease of reference, and has omitted the brackets which formerly surrounded his suggestions. The reason for the latter change is declared by Dr. Starr to be the belief that his additions are in the spirit of Dr. Goodhart's writings and entirely in accord with his views. In some respects, therefore, it will be seen that the present edition constitutes a new book.

The book as it stands is an admirable guide to the diseases incident to childhood. The Introduction will repay careful reading. The effort appears to have been made to give the student a good insight into the nature of the diseases mentioned, and to place before

him a clear description of the symptoms as they are seen at the bedside. This effort has been successful, and cannot be too warmly commended. The author (or the American editor) does not devote as much attention to the treatment of pneumonia as we could wish, and he omits all consideration of cerebro-spinal meningitis. His remarks on enuresis, however, are most excellent, and for making them he deserves the thanks of all parents and of all afflicted children.

TRANSACTIONS OF THE TEXAS STATE MEDICAL ASSOCIATION, Twenty-first Annual Session held at San Antonio, Texas, April 23, 24, 25, 26, 1889. 8vo, pp. 338. Austin, Texas, 1889.

The size of this volume speaks well for the interest which the members feel in their State Society. The papers are too numerous to enable one even to mention them all. Dr. H. A. West, of Galveston, in his paper on "Continued Fevers in Texas," says that typhoid fever occurs in Austin, and in various parts of Texas, despite the fact that a few do not meet with the disease; and that it does not occur in extensive epidemics, but sporadically. He thinks it is comparatively infrequent, and of mild type. Dr. George Dock, of Galveston, makes some instructive remarks upon the "Parasites found in Malarial Blood." Dr. Dock is well qualified to speak on this subject, and, as was to be expected, his remarks are clear, terse, and to the point. The same author also has a paper on "Leprosy—with a Report of Two Cases." He assumes that leprosy is a specific infectious disease, caused by the bacillus of Hansen and Weisser; but is forced to admit that the manner in which his patients (two men) acquired the disease is unknown.

These two men, for a period of at least thirteen years, moved among their fellows and in intimate relations with their wives and children; yet, he says, so far no other case of the disease has been acquired from them. Dr. Dock thinks the study of these cases will show that contact alone even when intimate and long-continued, cannot be a source of danger, and that other factors, as predisposition (of which we know nothing) and solutions of continuity, must play the most important part.

The volume before us is well printed, and altogether makes a very favorable impression.

LITERARY NOTES.

We have received the first number of the *Kansas Medical Catalogue*, which is to be issued monthly at a subscription price of \$1 a year. The first number contains twenty pages of reading matter, each about the size of that of the *REPORTER*. The Editor is Dr. F. F. Dickman, and the place of publication is Fort Scott, Kansas.

LONDON POST-GRADUATE COURSE.—The London post-graduate course was opened by an address by Mr. Jonathan Hutchinson, President of the Royal College of Surgeons, on "The Aims and Methods of the Post-graduate Course," at the rooms of the Medical Society in Chandos Street, on Jan. 8.

NOTES AND COMMENTS.

The Epidemic of Influenza in St. Petersburg.

Until quite recently an epidemic of influenza, which has now assumed serious proportions, both in Europe and America, was raging in St. Petersburg and some of the suburbs and neighboring towns—Peterhof, Gatchino, and Cronstadt amongst others suffering severely. In the schools of all grades from a quarter to a half of the pupils and teachers have been absent; the military hospitals, too, were so crowded that many of the men had to be treated in the barrack rooms, and the ordinary drill was seriously interfered with. Business was carried on but very partially, owing to the number of principals and employees who were laid up. The medical men—that is, those of them who were so fortunate as to have escaped—were “run off their legs,” and the chemists have been doing a thriving trade, chiefly in the sale of quinine to the public, who have largely come to understand the value of the drug in influenza. It is stated that one pharmacy of moderate size sold as much as a pound of quinine in two days. Dried raspberries, too, were reported to be so much in favor that it was impossible to procure any. In order, apparently, to make up to the public for the difficulty of procuring medical attendance, the lay press kindly took upon itself to instruct the uninitiated in the medical aspects of influenza. Thus, one of the first of the daily journals gravely stated that influenza was liable to be complicated with pleurisy, eczema, bronchitis, pulmonary phthisis, nephritis, otitis, catarrhal pneumonia, vaginitis, scabies, lymphadenitis, and soft chancre!—*Lancet*, Dec. 7, 1889.

Carbolic Enemata in Dysentery.

In the St. Petersburg weekly *Russkaia Medicina*, No. 19, 1889, p. 294, Dr. Ivan S. Kildueshevsky, of Bendery, describes forty-four consecutive cases of severe epidemic dysentery (in soldiers), successfully treated with washing out the large bowel with a weak carbolic acid solution, once or twice daily. The enemata (from one-and-a-half to two pints of filtered water containing two or three grains of the crystallized acid) were made with an Esmarch syringe. All the patients recovered, the average hospital

stay being about twenty days. The stools acquired a normal character about the fifth day of the treatment. The same remedy proved similarly successful in the author's own case. As far as Russia is concerned, the method was introduced by Drs. Shtchegloff and Kaxmpf.

A Case of Arsenical Poisoning.

A case involving the charge of wilful murder has just been tried in the County Limerick, Ireland. The prisoner, it seems, wanted to get rid of his father-in-law in order to secure his life insurance. In the stomach of the dead man 23 grains of arsenic were found, and as it was proved that the prisoner had made attempts to procure arsenic under false pretences, he was convicted of murder and sentenced to be hanged.

Tuberculosis from Cigars.

It is stated that a German physician, on examination of a number of cigar tips, found that many of them were infected with tubercle bacilli. The makers were tuberculous, and in the manufacture of the cigars, moistened the tips with their saliva.—*Canada Lancet*, January, 1890.

Sanitaria for Tuberculous Children.

Dr. Léon Petit, in a paper read before the Société Française d'hygiène (Journal d'hygiène, Sept. 5, 1889), stated that a number of prominent French physicians were interested in the establishment of sanatoria for the gratuitous treatment of poor children. Nine years ago the hospital of Villepinte was established for the treatment of tuberculous young girls, and now has more than two hundred beds. Unfortunately young boys are not respected by this disease, and an attempt was made to establish a second asylum for their reception; this was successful, and the Armeson Hospital, containing forty beds, has been opened. The Association had been offered a large tract on the Mediterranean, situated in a forest of pines at the base of the Esterel Mountains, for the establishment of a convalescent sanitarium. He recommends the establishment of sanitarium colonies for those that have been bene-

fited by the sanatoria. because to these children the cities are dangerous, as they favor the reappearance of what may, in outdoor life, become a latent disease. It is to be hoped that this Association will succeed in realizing their ideal, and the experiment will be watched with much interest.—*New York Medical Journal*, Jan. 11, 1890.

Drunk or Dying.

These cases are among the most difficult to deal with that can occur in hospital practice, and it is no wonder that young house surgeons dread the very name of them, associated as it often is with offensive remarks at inquests and abusive newspaper paragraphs. Some excellent remarks on the subject were not long ago made by Mr. Durham at Guy's Hospital, London, and quoted in the *London Med. Recorder*, Dec. 20, 1889, from which we extract the following "aphorisms" as likely to be useful to practitioners who are by way of being called upon to treat "drunk or dying" cases. After saying that in any doubtful case it is best to err on the safe side, Mr. Durham went on to point out that the cases might be divided into three classes:—First, those who lay quietly and comfortably in bed upon their backs remembering little of the accident, but quite happy. Second, those who tossed the clothes off, were irritable, refused medicine, and would not lie still. Third, those who lay exactly where they were put, whether the position was a comfortable one or not. Of the first class no fears need be felt; they would probably do well. The second should be regarded with suspicion. Of the third there was cause for the gravest anxiety.

English Leprosy Fund.

It is announced that the Prince of Wales took the chair at a public dinner at the Hôtel Métropole on Monday, Jan. 13, for the purpose of appealing to public sympathy to aid in the promotion of a National Leprosy Fund. It is proposed that the interest arising from such fund should be devoted to the medical treatment and care of indigent lepers in the British Empire, and that a sum of money be set apart and placed under the control of trustees for the endowment of two scholarships, one student to

make the United Kingdom and the remainder of Europe his field of investigation, and the other to go abroad and study the disease in India, China, the colonies, and elsewhere. There are, at present, two lepers in London.

Comedones.

For the removal of "black heads" or comedones, Dr. Unna used the following application:

China clay	4 parts
Glycerine	3 "
Acetic acid	2 "
Perfume, sufficient.	

The parts affected should be covered with this ointment in the evening, and, if necessary, during the day. After several days, all the comedones can be easily expressed, most of them coming out on washing the parts with pumice stone soap.

Another entirely different treatment is proposed by Dr. McCassey, who, having noticed that comedones were easily pressed out of the skin of a patient who had been under the influence of ether, devised the following mixture which he used in several cases with success:

Ether	f 3j
Carbonate of ammonium . . .	gr. xx
Water, to make	f 3ij

The liquid was applied to the affected parts twice a day.—*Druggists' Circular*, Jan., 1890.

Danger of Strophanthus in Renal Disease.

On examination of sections of the kidney after experimental poisoning with extracts of strophanthus, Dr. Ergasse invariably found the kidneys hyperemic—partly in the cortex, partly in the medullary zone, but chiefly at the tips of the pyramids. He therefore warns us that clinically we must bear in mind that where there is coincident nephritis, preparations of strophanthus are contra-indicated, otherwise an increase of the renal trouble may readily supervene. There is pretty general agreement that the action of the drug is most satisfactory in mitral disease, care being always taken that the degeneration of the myocardium has not pro-

ceeded too far. Hence it is best not to prescribe it in advanced stages of heart disease, especially when this is accompanied by arterio-sclerosis and intestinal nephritis.—*Practitioner*, Dec., 1889.

The Progress of the Influenza in Europe.

Accounts daily received from the Continent show a rapid extension of the area involved in the prevailing epidemic. Indeed, it has truly become pandemic. The march of the disease has been almost steadily from east to west, and yet it has shown a certain capriciousness in visiting certain cities in the west (e. g., Paris) before appearing in some that are situated further east. Having almost died out in St. Petersburg, it is still very prevalent at Vienna, where it shows no signs of abatement. In Berlin also it has continued to prevail, and has appeared in all parts of Germany, from Hanover in the north to Saxony in the south. It has appeared in Belgium at Brussels and Antwerp, and in Holland at the Hague. It has invaded Italy, cases being noted at Verona; whilst in Spain and Portugal, Barcelona, Madrid, and Lisbon have become centres of the epidemic.

The Berlin correspondent to the *Lancet*, Dec. 28, 1889, writes that the influenza epidemic has gained much ground during the last week or ten days in that city. Professor Senator declares that it has also assumed a somewhat severer character. In some cases the symptoms are so alarming that one might have taken them at first sight for severe cases of typhus. Apart from the usual symptoms observed were deep stupor, pains in the limbs, and general morbid irritability.

Injections of Defibrinated Blood in Chlorosis.

In a thesis maintained by Dr. Antiqu before the Faculty of Medicine of Lyons, he relates the results obtained by a novel method of treating chlorosis suggested long since by Teissier. The material employed is the blood of oxen defibrinated. About 5 ounces of this is injected *per rectum* twice a day for a week. The treatment is discontinued at the end of that period for a week, and then recommenced. Care should be taken to warm the blood over a water-bath

before injecting, and the patient should be directed to retain it as long as possible, any colicky symptoms being overcome by the addition of a few drops of laudanum. According to the author, this treatment is more rapidly and certainly successful than any other at present resorted to. The proportion of red corpuscles in the blood promptly increases, and the mucous surfaces regain their normal color. He attributes the rapid improvement that takes place to the fact that the employment of defibrinated blood fulfils three indications—(1) restitution of the iron; (2) restitution of oxygen; and (3) restitution of the salts of potash and the chlorides. Dr. Huchard, commenting thereupon, mentions that, in a case of his own, he had succeeded in overcoming an anemia which had resisted all medication.—*London Med. Recorder*, Dec. 20, 1889.

Prolapsus Recti due to Stone in the Bladder.

At the last meeting of the American Pediatric Society (see *Transactions*, Jan., 1889), Dr. A. Caillé, of New York, reported the case of a female child, three and one-half years old, with the following history: About one year before presentation the child's gut was found prolapsed after each stool, and she appeared to be in great pain in passing her urine. She was taken to a number of physicians and dispensaries for treatment, and presented at almost all the clinics as a case of inveterate and severe prolapsus recti, and many methods of treatment were tried without affording the child the slightest relief or improvement. At his first examination Dr. Caillé found the child to be anemic, nervous, and cachectic in appearance, and suffering from diarrhoea and bronchitis. The rectum was prolapsed two inches, and during the examination it came down fully seven inches, and presented a slightly bleeding surface. A straining effort on the part of the child forced urine from the bladder, which was collected, and found to contain pus and much epithelium, as evidence of cystitis. The sphincter ani was relaxed to such an extent that three fingers could be passed through it without an effort. The child was then anesthetized, and a more careful examination showed the presence of a large stone, free, in the cavity of the bladder.

Speedy removal of the stone was suggested,

and the supra-pubic operation decided upon, on account of the large size of the stone and the facility of access by this operation. The bladder was first thoroughly irrigated with a warm solution of boro-salicylic acid, and, after division of the skin in the linea alba, the patient was put in Trendelenburg's position, with head low and raised pelvis, by which means it was comparatively easy to avoid the reflection of the peritoneum. It was not found necessary to raise the bladder by inflating the rectum,—two fingers of an assistant passed into the rectum being sufficient to bring bladder and stone into a convenient position above the symphysis. The bladder was now incised and the large stone removed with some difficulty, thereby producing slight laceration of the margin of the incised bladder.

Owing to this slight and unavoidable laceration primary union was not contemplated, but the bladder was sutured, nevertheless, and the wound filled with loose iodoform gauze, and the usual antiseptic dressing applied. The temperature of the patient was normal throughout the entire healing process, except on the third day after operation, when it rose to 102° F. for a few hours. The process of healing was all that could be desired, excepting a small leak in the suture, which was detected on the fourth day. At the end of three weeks the wound had closed, and the child was discharged cured.

During the time of convalescence the rectum came down once, and not again afterwards. The stone was twice as large as a pigeon's egg and weighed twenty grammes. Its presence in the bladder of the child had evidently caused the rectum to prolapse as a direct consequence of frequent straining, and its removal permitted the parts to assume their normal and natural condition.

Phthisis in High Altitudes.

From a report by Dr. L. Schrötter on the distribution of phthisis in Switzerland, it would seem that the inhabitants even of high altitudes are by no means so free from phthisis as we are wont to suppose. The tables of deaths for the eleven years 1876–1886 show that phthisis is endemic in every part of Switzerland, not a single district being free from it. On the whole, the deaths from this cause are fewer in the high than in the low-lying districts, but it cannot be said that the mortality from this cause is in-

versely proportionate to the altitude. Whenever there is a large industrial population the phthisis mortality is considerable. Industrial populations always suffer much more than agricultural populations where the altitude is the same.—*Lancet*, Dec. 14, 1889.

Local Treatment of Diphtheria.

Regarding the local treatment of diphtheria, Mr. Alfred Stanley, in the *British Medical Journal*, Dec. 14, 1889, recommends the following most highly:

1. By means of a tube blow a portion, say half a drachm, of sulphur over as much as can be covered of the diphtheritic membrane.

2. Gargle with a solution of the sublimed sulphur, or, if preferred, with sulphurous acid mixture.

3. Inhalation of the fumes of burning sulphur. The first means should be used twice a day, night and morning, and the two latter ones every two hours.

Mr. Stanley claims that no fungus can possibly exist under the fumes of burning sulphur, and that its action is to completely shrivel up the diphtheritic membrane, putting to death the micrococci as fast as they are formed, the membrane eventually peeling off, leaving a healthy healing surface.

Erasion of the Knee-joint.

Mr. Joseph Collier, of Manchester, describes in the *Annals of Surgery*, Dec. 1889, the operation of erasion of the knee-joint. The operation itself is indicated especially in tubercular and synovial diseases of the joint. Erasion of the knee-joint was first performed in 1881. The mode of operation as performed by Mr. Collier is as follows: An incision, slightly convex downwards, is made from one femoral condyle across the middle of the patella to the other condyle, the skin is dissected upwards and the patella exposed; this bone is then sawn across, or, in the case of young children, divided with a stout scalpel and the two halves turned upward and downward. To do this, longitudinal incisions are made through the tissues on each side of both halves of the patella, upward as far as the upper limit of the synovial pouch and downward nearly to the anterior tubercle of the tibia. The lateral ligaments are freely divided and the whole of the anterior and lateral parts of the capsule together with the

semi-lunar cartilages and synovial membrane are cut away with scalpel and scissors, taking care to enucleate and dissect out the whole of the upper synovial pouch. All synovial membrane and pulpy material is removed from the neighborhood of the patella and its ligament. Next the condyles of the femur, crucial ligaments and upper end of the tibia are carefully cleaned, every particle of diseased tissue being cut or scraped away. Next by flexion and rotation of the loosened joint all the diseased synovial membrane and capsule at the back of each condyle and in the inter-condyloid notch, as well as behind and between the crucial ligaments, is completely removed. This is the most difficult part of the operation, but is in most cases possible without division of the crucial ligaments, provided the lateral parts of the capsule have been thoroughly removed. If the crucial ligaments are infiltrated with tubercular material, or if they really prevent complete eradication of the disease, they should be taken away, but it is better to preserve them if possible; they are, however, not essential to a good result. Great care must be taken to thoroughly remove the whole of the semi-lunar cartilages, and the synovial membrane at the back of the joint, since it is here that diseased material is likely to be overlooked, and here often caseous foci and even localized abscesses are found.

After thus dissecting away all the morbid tissue in the soft parts, often leaving the lower end of the femur quite stripped, if the disease has extended beyond the limits of the synovial membrane, the bones must be carefully inspected, and any little pits or doubtful spots in the articular cartilage or on the bony surfaces must be gouged out or scraped away. Still more care, of course, must be taken if any deeper focus of disease in the bone is laid bare by removal of the softer tissues. All morbid material must be taken away, but no healthy bone sacrificed. Since, as a rule, tubercular disease of the knee is primarily and principally synovial, the bone lesions in cases in which the possibility of erosion can be seriously considered will be found for the most part superficial and local. In some cases we employ the actual cautery (Paquelin) to sear any doubtful spots, but it is far better to cut wide of them.

After making quite sure that all disease is removed the joint is well doused with antiseptic lotion, any visible vessels are lig-

atured and then the Esmarch's tourniquet is taken off, and arrest of the principal bleeding points secured. A mixture of equal parts of powdered iodoform and boracic acid is then well dusted over and rubbed into the surface and all recesses of the wound, the patella is sutured by catgut sutures carried through or around the two halves. Drainage is then provided for by forcing a blunt raspatory through the tissues at the back of the joint on each side of the limb, and cutting down upon it through the skin. A tube is passed through such aperture, and the front wound is then sewn up. After dusting the wounds with iodoform and boracic powder, a double layer of wet gauze is laid over the incisions and the whole knee packed thickly with wood wool wadding, of which a dressing some 3 or 4 inches thick, at least, should be used. This is firmly bandaged on and the limb fixed upon a bracketed back splint with a foot piece.

Treatment of Acne.

The following treatment for acne has given good results: the paste, given below, should first be spread on the skin to the thickness of the blade of a knife, and rubbed off in a quarter of an hour, after which the skin should be dusted with talc:

R Naphthol ʒ iiss
Sulph. precip. ʒ jss
Canolini,
Sapon. vicid aa ʒ vij
M. et f. pasta.

Intertrigo.

Intertrigo, or chafed skin, is such a common affection that it is generally overlooked, except, perhaps, the application of any available salve. Yet it is often painful and may under certain circumstances result in eczema. Again, the application of unmedicated ointments may do considerable harm by increasing the superficial inflammation and becoming rancid. A simple and most efficacious salve is the following, which we quote from the *Journal de Méd.*, Nov. 10, 1889:

R Acid. borici gr viij
Lanolini ʒ jss
Vasellini ʒ iiss
M. et fiat. unguentum.

NEWS.

—Madrid, Spain, has one physician to every seven hundred of its inhabitants.

—Dr. Ezra Comly, of Philadelphia, died suddenly on Jan. 4, 1890, aged 49 years.

—A committee has been formed in Paris with the object of raising a monument to the memory of Philippe Ricord.

—At a meeting of the New York Academy of Medicine, held January 2, Dr. R. C. M. Page was elected Vice-President.

—It is stated that vaccination is being introduced among the natives of the Lower Congo by the doctors of the Belgian Expedition.

—The total number of cases of influenza in Berlin on January 12 was estimated at 400,000. There have been 650 deaths due to the disease.

—The new city hospital of Baltimore, Md., was formally taken charge of last week by the faculty of the College of Physicians of that city, on which occasion a reception was given to the medical profession at large.

—"La Grippe" is at its height in Michigan. According to the report of the State Board of Health, for the week ending Jan. 4, 77 per cent. of the physicians heard from reported the prevalence of the disease.

—It is reported from Ingersoll, ten miles west of Texarkana, Ark., that a woman gave birth to four finely formed and well developed girl babies on Jan. 11. The mother is doing well, but the father is reported to be prostrated from sheer joy.

—Cleveland, New York, has a new city hospital containing one hundred and fifty beds. The patients are all under the care of one physician, who receives a salary of \$1,200. There is no visiting staff, and all work, surgical as well as medical, falls upon the single medical officer.

—The assessors and reporters of New York have been trying to find out the value of the property held by the New York Hospital. The managers of the institution, claiming that its property, being exclusively for charitable uses, is untaxable, refuse to disclose the amount of its possessions.

—At the recent trial of a quack in Alabama, for violating the provisions of the medical statute, and his conviction, it was ascertained that there was no penalty affixed to the crime. The alleged reason for this is that the law was so tampered with during its passage through the Legislature that the penalty was omitted.

—The Montgomery County Medical So-

ciety held their regular meeting at Norristown, January 8, and Dr. Alice Bennett, resident physician at the State Hospital for the Insane, was elected president. It is not known that a woman physician has ever before held this office in a medical society, composed almost exclusively of men.

—The Jewish Hospital Association, of Philadelphia, held its twenty-fifth annual meeting Jan. 12. The report showed that 432 patients were treated in the hospital and 1,380 in the dispensary, a total of 1,812 persons. The receipts for the year were \$30,162.63 and expenses \$29,677.54, leaving a balance in the treasury of \$485.09.

—Lewis Hall Sayre, M. D., a son of Dr. Lewis A. Sayre, died suddenly during the night of the 2d inst. The deceased was a graduate of Bellevue Hospital Medical College, of the class of 1876, and at the time of his death was the President of its Alumni Association. Dr. Sayre was associated with his father and with his brother in practice, and was well-known among the profession.

—The Presbyterian Hospital, of New York City, has so far recovered from the effects of the fire as to be in good working order with sixty-four beds. The new dispensary building is used as a ward. Being very thoroughly ventilated, it is admirably adapted for this purpose. It will accommodate forty patients. The chapel in the administration building has also been fitted up as a ward containing twenty-four beds.

—Dr. Oliver P. Rex, of Philadelphia, died from the effects of the grip on Sunday, Jan. 5. A few days before he was taken with the disease, but he kept up hoping to fight it off and forget it in the duties attending an extensive practice. Pneumonia developed, however, and brought about a fatal termination. He was a graduate of the University of Pennsylvania, and was an attending physician to the Jefferson College Hospital and Presbyterian Hospital.

—The Medical Society of the District of Columbia has elected the following officers for the ensuing year: President, Dr. S. M. Burnett; Vice-Presidents, Drs. G. N. Acheson and G. W. Cooke; Treasurer, Dr. C. W. Franzoni; Corresponding Secretary, Dr. T. C. Smith; Recording Secretary, Dr. S. S. Adams; Librarian, Dr. J. H. Mundell; Board of Censors, Drs. G. C. Ober, J. T. Winter and L. L. Frederich; Board of Examiners, Drs. C. H. A. Kleinschmidt, G. N. Acker, S. S. Adams, L. Eliot and H. L. E. Johnson.

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